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THE DIAGNOSIS AND TREATMENT OF THE PSYCHOPATHIC OFFENDER IN THE UNITED STATES

By

Archibald F. Ward, Jr.

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TABLE OF CONTENTS

LIST OF TABLES

PART ONE

INTRODUCTION

CHAPTER I

THE PROBLEM

A large part of the present dilemma facing society in regard to the psychopathic offender is epitomized in this statement made by the superintendent of a state mental hospital caring for some 3500 patients: "In our state the law says that we cannot keep psychopathic personalities in our institutions. If they are not psychotic, we are supposed to discharge them. The courts will not convict them for their petty crimes; so they constantly send them back through an old jury commitment procedure, and they remain in the hospital until they come before the staff again, which is about two weeks. The staff invariably sends them back to society. They continue to commit these petty crimes and the authorities will not convict them.

" . . . I realize the trouble that these psychopathic personalities give to society as well as to the superintendents of different institutions. In our institutions, they are admitted perhaps five or six times during the course of a year, which requires a lot of expenditure; and when we turn them out, some member of the legislature will call us up and say that the patient is crazy and ask us to

keep him in the institution. Then the staff comes along saying that he is not psychotic, only a delinquent patient, so we let him go again."[1]

Many students of human behavior, particularly some of those in the medico-legal field, are well aware that the psychopathic offender constitutes an urgent and baffling problem in regard to crime control. Indeed, the statement quoted above is but one of many expressions of confusion, distress, bewilderment, or warning concerning the problem facing society on account of the existence of psychopathic offenders. Thus it is realized in at least some circles that the existence of the psychopathic offender constitutes a "problem" of a serious and urgent nature.

But what, more precisely, is the nature of this urgent problem? Can it be stated in terms which go beyond expressions of frustration, apprehension, or largely unrelated, or at least non-systematic, generalities? At any rate, a serious attempt to sharpen and delimit the problem is long overdue.

In making an effort of this sort, it is first necessary to determine the general conceptual boundaries within which the investigation is to take place. That is to say, what aspects of the problem deserve priority in consideration? It is a matter of the psychopathic offender and

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[1]C. M. Speck, in the discussion on Lawrence F. Wooley, "A Dynamic Approach to Psychopathic Personality," Southern Medical Journal, vol. 35, no. 10 (Oct. 1942), pp. 933-934.

what? Obviously, the larger problem would have to be stated in terms of the psychopathic offender and society. Equally obvious is the fact that some particular segment of society must be the prior locus of investigation. But what segment? It seems reasonable to assume that those agencies and institutions which are related in some specific way to crime control activities constitute the segment of society which can yield the most satisfactory information about the psychopathic offender.

It is advisable to state the problem in terms of hypotheses which can be investigated and which can be demonstrated to be either true or false. The following hypotheses are believed to represent significant facts concerning the relationship between the psychopathic offender and the crime control agencies and institutions, and constitute the problem to be investigated:

(1) Among criminals and delinquents there are some whom authorities in the field designate by the term "psychopath" or by some other term which is used in a way roughly equivalent to this term. (2) Authorities in the field are in general agreement that this psychopathic offender is materially "different" from other kinds of law-violators -- different from other kinds of mentally abnormal offenders as well as different from those who are considered not mentally abnormal. Furthermore, (3) many "key" persons in agencies and institutions entrusted with the responsibility for crime control are not aware of the need for

distinguishing between psychopathic and non-psychopathic offenders. On the other hand, (4) many others are aware of the need for this distinction but, considered as a whole, lack adequate diagnostic preliminary procedures and treatment facilities, and show considerable diversity in regard to diagnostic criteria.

It is generally agreed that crime control includes at least such matters as pertain to detection and treatment. Obviously, the offender has to be detected (in the sense of being found out and apprehended) before any treatment can be applied. Once the offender has been apprehended, brought before the court and found guilty, the next problem concerns what is to be done with him. The measures then taken for the sake of both the offender and society constitute the "treatment" as the term is used in the present study. This use of the word does not necessarily imply "cure," although curative, or at least remedial, measures are surely the goal. Many forms of illness are not "curable;" nevertheless, the patient is "treated" in the sense of being hospitalized or provided with other forms of special care or attention. And of course treatment sometimes includes various degrees of isolation or quarantine if such measures are indicated for the welfare of society.

A rational approach to crime control includes the proposition that basically different kinds of offenders (with different causes for their criminality) should be

treated in different ways. If the aim in treatment is not to "let the punishment fit the crime" but is rather to let the punishment, or other form of treatment, fit the criminal, then it is obvious that methods must be employed to determine the kind of offender with which the courts or other agencies are dealing. This means, of course, that proper diagnosis is fundamental to rational treatment. Therefore, a portion of this study will be devoted to diagnostic procedures and criteria.

Diagnosis, broadly considered, may be divided into two parts: (1) diagnostic criteria proper and (2) preliminary procedures. Of these two parts, the importance of adequate criteria is self-evident. However, before any diagnostic criteria can be applied, certain preliminary procedures are necessary. To illustrate these two phases of diagnosis, let us assume the case of a man being tried before any given court. Let us suppose that the court is interested in knowing whether or not this offender is psychopathic. The very fact that the court desires this information is preliminary to the use of any diagnostic criteria. Thus the person or agency having the responsibility for saying whether or not an examination for psychopathy shall be made is in a key position in the whole diagnostic structure. Furthermore, if it is desired to examine an offender for possible psychopathy, it is important to know what diagnostic facilities, if any, are available, for the presence of diagnostic facilities is

also preliminary to any actual examination.

As has already been stated, crime control includes at least detection and treatment, and diagnosis is essential for a rational approach to treatment. Since procedures for detection in the sense of apprehending the offender qua offender rather than as any particular kind of offender are generally considered to be roughly the same for all who violate the law, this phase of the crime control problem need not be considered in the present study. This means that the other principal part of the problem centers about treatment. As has already been shown, accurate diagnosis is essential for rational treatment. Therefore, this study will concentrate on the situation as it revolves about the diagnosis and treatment of the psychopathic offender.

The specific questions to be investigated are the following:

1. To what extent are persons and agencies entrusted with the responsibility for crime control aware of the need for distinguishing between psychopathic and non-psychopathic offenders? To put the matter rather baldly, are they at all acquainted with the psychopathic concept?

2. What is the reported incidence of the psychopathic offender? and what do these reports tell us about the use of the concept?

3. What person or agency has responsibility for diagnostic procedures?

4. When is the diagnosis made?

5. What methods are employed in making the diagnosis?

6. What psychiatric and psychological services are available for crime control agencies and institutions?

7. What provisions are there for re-examination in order to determine the accuracy of the first diagnosis?

8. What diagnostic criteria are employed?

9. Is there a felt need for better clarification of the concept?

10. From the standpoint of providing a rational basis for treatment, what is considered to be the etiology of the psychopathic offender?

11. In terms of the present facilities, what disposition is made of the psychopathic offender?

12. How is he handled within the institutions to which he is sent?

13. To what extent is he segregated within these institutions?

14. What kind of probation and parole risk is the psychopath considered to be?

15. To what extent is the behavior of the psychopathic offender considered to be modifiable?

16. Are any psychopaths known to have been cured? and if so, what were the salient factors in the cure?

17. Do key persons engaged in crime control work think that the psychopathic offender should be treated differently from others who break the law? and, if so, what should be the main difference in methods of treatment?

Before attempting to answer these questions, it would seem necessary to analyze the early literature in the field. This will be done in Chapter II under the headings (1) terminology employed in the designation of psychopathy and (2) the principal characteristics of this condition as described by the early authors. In this way we can see the present problem in its historical setting and also make a beginning in the examination of the hypothesis that authorities in the field are in general agreement that the psychopathic offender is something sui generis.

We shall next turn our attention to the methodology employed in this investigation. The sources of information which will provide the most adequate answers to the questions to be investigated are considered to be (1) the current literature in the field and (2) a questionnaire-survey of key persons in crime control agencies and institutions. Methods employed in securing this information and in the subsequent handling of the material will be considered in detail in Chapter III.

Part Two of this study deals with the present status of concept and practice. The results from the study of current literature and the questionnaire-survey are considered together under the following headings: extent of acquaintance with the concept (Chapter IV), reported incidence of the psychopathic offender (Chapter V), diagnostic procedures and facilities (Chapter VI), diagnostic criteria in current literature (Chapter VII), diagnostic

criteria in agencies and institutions (Chapter VIII), etiological formulations (Chapter IX), therapy in practice (Chapter X), and prognostic judgments and therapeutic ideals (Chapter XI).

Part Three deals with such recommendations as seem indicated by this investigation. These concern diagnostic criteria (Chapter XII), diagnostic procedures and facilities (Chapter XIII), and therapy (Chapter XIV). A final chapter gives a summary of the entire study.

One can hardly be expected to conduct a study of so vital a problem without reaching certain tentative conclusions regarding the validity (or at least the pragmatic value) of the methods now being employed. In particular, there is an obligation to point out such basic contradictions as may appear. Furthermore, there is an obligation to attempt some solution of such contradictions. This can be done by weighing the evidence carefully, by examining for consistency, and by using critically the body of information upon which there is essential agreement.

It is hoped that this investigation will force attention upon the diagnosis and treatment of the psychopathic offender and bring the whole question into sufficiently clear focus to require a great deal of further investigation into the myriad details and extensive ramifications of the baffling problem which at present confronts us.

CHAPTER II

THE PSYCHOPATHIC CONCEPT PRIOR TO 1975

The purpose of this chapter is to present a brief analysis of the concept of psychopathy prior to the year 1975. The terminal date of this analysis thus merges with the beginning date of the far more pertinent and complete survey of current literature reported upon in Part Two. Inasmuch as the emphasis of the present study is upon *current* concepts and practices in regard to the psychopathic offender, a complete narrative history of the concept of psychopathy would be out of place in this setting. Moreover, several narrative summaries of the early literature are already in print -- e. g., those in D. K. Henderson's *Psychopathic States*, Hervey Cleckley's *The Mask of Sanity*, Paul W. Preu's "The Concept of Psychopathic Personality,"[1] Gregory Zilboorg's essay on "Legal Aspects of Psychiatry"[2] and Sydney Maughs' "A Concept of Psychopathy and Psychopathic personality: Its Evolution and Historical

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[1] In *Personality and Behavior Disorders* (J. McV. Hunt, ed.)

[2] In *One Hundred Years of American Psychiatry* (Hall, Zilboorg, and Bunker, eds.)

Development."[3]

This chapter is organized around the headings of (1) terminology employed in the designation of psychopathy and (2) principal characteristics of this condition as described by the early authors. The source of the material employed in this analysis is the excellent historical study by Maughs, except in those instances where other authors are cited. Appendix A-1 shows the approximate date of the authors cited by Maughs, while Appendix A-2 gives the terminology employed by these authors.[4]

Terminology Employed in the Designation of Psychopathy. The name given to this condition is the logical starting point in this analysis of the early literature. Maughs does not actually state the terminology used by each author in every case. In many instances it may be assumed that the terminology is the same as for others being discussed in any given section. However, in this analysis of terminology the presentation is entirely on

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[3]Journal of Criminal Psychopathology, vol. 2, no. 3 (Jan. 1941): 329-356; vol. 2, no. 4 (April 1941): 465-499. This is by far the most complete historical study discovered by this investigator.

[4]Maughs' study includes several authors whose works are not considered in this connection; some of these fall in the period after 1935, and others, though publishing material prior to that time, have made such substantial contributions since that date that they are considered in those portions of the present study dealing with current literature.

the basis of the terms actually stated to have been used by the specific authors. The table given in Appendix A-2 lists twenty-two different terms in order of their appearance in the literature and indicates also the authors by whom these terms were employed. It will be noted in a few instances that the same author designated the condition by more than one term.

The very earliest terms -- "melancholie sans délire" and "manie sans délire," employed by Ettmüller and Pinel, respectively -- indicate a differentiation from other types of mental disorder: the condition is one set off by sans délire.

Terms which include the word moral were the ones which predominated in the literature prior to 1935. Outstanding among these is "moral insanity," which was introduced by Prichard in 1835 and which was employed by Hirsch and Steen as late as the first decade of the twentieth century. The term "moral imbecility" was employed as early as the time of Kiernan in the latter part of the nineteenth century and as late as the days of Shrubsall and M. H. Smith in the third decade of the twentieth century. Whatever may be the disadvantages of terms such as these, they nevertheless imply a distinction between this condition and criminality of the non-insane variety (because this kind of criminal behavior is characterized also by "insanity" or "imbecility") and other kinds of "insanity" (because this kind of mental derangement is

characterized also by serious defect in "moral" functioning).

Principal Characteristics of the Condition. We turn now to the meaning given these various terms. In order to present the information as concisely as possible, the principal characteristics of the condition under consideration are given, author by author, in the following summary form:[5]

Author	Summation of Principal Characteristics of the Condition
Pinel	Without "lesion of the understanding, but . . . under the dominance of instinctive and abstract fury, as if the active faculties alone had sustained injury"
Esquirol	"Moral alienation" "passions and moral affections" disordered Difficult to discover any hallucinations
M. Georget	Modification of madness Morbid state of feelings and active principles of the mind, often lasting throughout life
Rush	Derangement of the will Vicious actions Untruthfulness -- mainly of "hyperbolical or boasting nature"
Prichard	Previous "attack of madness" Begins after severe shock or loss or physical injury, but in some cases accentuation of traits "which were always more or less natural and habitual" Perversion of natural feelings, affection, inclinations, temper, habits, moral dispositions, and natural impulses

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[5]In this summation, the words enclosed in quotation marks were quoted by Maughs, and many of the non-quoted phrases are those given in Maughs' narrative account.

	Without hallucination Includes "excitement" and "melancholy dejection"
Falret	Periods of exaltation preceding general paralysis Schizophrenia (hebephrenic type), anxiety and phobic states, and obsessive neuroses seem to have been included Ruled out hypomania
Gouster	Morally perverted from infancy -- headstrong, malicious, disobedient, irrascible, lying, neglectful, frequently violent and brutal Great aptitude for certain careers -- e. g., mechanical pursuits Given to excesses Judgment enfeebled Hypochondriacal and later paranoid Physical stigmata -- irregular development of cranium, assymetry of face, very small or very large ears, adherent lobules of the ear Hereditary antecedents in many cases
Savage	Not a fixed or permanent condition -- but rather stage or state of mental disease
Tuke	Lying, thieving, committing acts dangerous to others; in marked contrast to environment of the person concerned, with absence of any sufficient motive
Verga	Often a prelude to insanity Some subjects saw no wrong in their acts Some said they understood their acts to be wrong, but claimed their impulses were irresistible Brutal criminals were a combination of these
Michetti	Sentiments of self-advantage and self-benefit prevailing over sentiments of duty and fraternal love, producing loss of equilibrium in the intellective and affective functions
Morselli	Closely analogous to Lombroso's congenital delinquent Devoid of ethical sense
Buonomo	Perversion of moral sense

Lombroso	Characteristic physical signs: Big lower jaw, outstretched ears, projecting face, retreating forehead Clinical characteristics: Sensory obtuseness, analgesia, left-handedness, muscular agility, great development and robust form, precocious development, precocious sexual development, sphygmographic insensibility, daltonism Impetuosity, marked contrast between various manifestations of their character, great irrascibility with its intermissions Preoccupation with present moment
Bleuler	Instinctive criminality
Barr	Occupied entirely with own ego
Nacke	Predominance of ethical and aesthetical defects Inclination to immoral and dangerous conduct Indication of degeneration in skull, face, and body
Koch	Defects preventing individual from adjusting in his environment
Hirsch	Habitual and aimless lying
Stedman	Delusions present Suspected relationship to paranoia
Wright	Exaggeration of normal, universally constitutional tendencies in persons who lacked inhibitions History of abnormalities from an early age, the individual never having appeared altogether normal
Steen	Idiots and imbeciles displaying immoral propensities Moral defectives -- displaying vicious or criminal tendencies from early age
Mercier	"Persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect" Combination of persistent vicious conduct with initial mental defect
Tredgold	Unable to resist ordinary temptations

	Absence of all shame and remorse Some have morbid obsessions
Birnbaum	Pathological affectivity Not to be identified with criminality
B. Glueck	Marked deviations from average child in truancy, backwardness with repeating of grades, lack of interest, dislike of discipline, extreme mischievousness Unusual lack of all conception of sex morality Work career extremely irregular and inefficient Without goal or object
Sandoz	Study of girls: Stubborn, deceitful, saucy, troublesome, slack At other times cheerful, kindhearted, gentle, lovable Delinquency usually began before ten Sudden changes in emotional tone
Froukel	To be determined by past history of patient Demarcation from normal was gradual and arbitrary Different traits for his different groups, but include: instability, pathological swindling and lying, heightened sense of self-regard, unstable in relations with opposite sex, lacked normal inhibitions and self-restraint, developed sickness under discipline, alcoholic intolerance, timidity with opposite sex and sexual abstinence until marriage
Visher	In study of veterans; Impossible to hold one course of action long enough to succeed Poor inhibition Crimes of passion Sensual excesses of all kinds Egotism, boldness, vanity Irritability Blaming others for his failures Emotional instability and impulsiveness Continual conflicts with family, employers, associates Lack of judgment Numerous eccentricities and unsound beliefs Non-conformity to social and ethical standards Following course of least resistance

	Failure to profit from experience Opinion of society had little deterrent effect Numerous evidences of maladjustment in marriage Some alcoholic and drug history Desertion and courtmartial common Work record after discharge from service was poor Hypochondriacal tendencies
Thom and Singer	Inability to use their intelligence to guide behavior Ill-considered acts to gratify appetites of the moment, without consideration of consequences Often plausible and superficially shrewd Incapable of steady application, soon tiring of any task
Huddleson	Emotional instability Some present paranoid personality Wandering from place to place and from occupation to occupation Poor cooperation and refractoriness to treatment Unreliability Some form of conduct disorder Conscious exaggeration
Scott	Egocentric Difficult personality traits Symptoms of nervous instability Poor balance Bad moral standards Frequently dishonest Extremely undependable Usually active trouble makers Often given to violent outbursts of temper
Johnson	Bad natured when frustrated Forgot the past Thought hopefully or not at all in regard to the future Motivated entirely by the desire of the moment Knew no fear Inhibitions weak and evanescent
Herd	"Persistent liar" "Persistent thief" "Persistently cruel, passionate, and vindictive"

	"The prey of irresistible impulses toward wrong-doing" Lack ability to do the right and refrain from the wrong
Suttie	Failed in their intuitive appreciation of feelings and attitudes of other people Mischievous, antagonistic, actively and intentionally anti-social Insensitive, selfish, unscrupulous Unstable, explosive Dominated by the emotion of the moment
Tredgold	Devoid of all moral or altruistic feeling Lacked discrimination and judgment and capacity to look ahead
Shrubsall	Callous Ruthless Extremely selfish No appreciation of punishment
Scheetz	Defect of judgment "Mentally myopic" Concern with immediate values only
Richmond	In childhood hard as nails physically, in contrast to the psychoneurotic child Unteachable, unable to respond to training Superficiality of emotional life A super-egoist Demand all and give nothing Possessor of very irregular abilities
Woods	Persistence from early childhood onward Obvious disadvantageousness of this behavior to the person involved Unteachable by experience Immediate rewards as chief objective Inadequacy or perverseness of feelings which motivate behavior Tendency to slip into psychoses or psychoneuroses
Partridge	Hopeless to attempt subdivision or presentation of characteristic reaction-type; rather consider in terms of socialized behavior Sociopathy: anything deviated or pathological in social relations, whether of individuals with one another or within or

towards groups, as well as in the relations of groups to one another
The group displays persistent and chronic sociopathic behavior

Schneider — Descriptive types:
1. Hyperthymic
2. Depressive
3. Insecure
4. Fanatic
5. Self-seeking
6. Explosive
7. Affectless
8. Weak-willed
9. Asthenic

Healy — Chronic abnormal social and mental reactions to the ordinary conditions of life, when behavior cannot be classified in the insanities, neuroses, or mental defectives
Generally some physical anomalies, either structural or functional
Often egocentric, selfish, irritable, very suggestive, easily fatigued mentally
Sometimes feeling of abnormal importance
The great ease with which they fall into anti-social conduct

Kahn — Psychopathic personality includes the following descriptive types falling in the area between mental normality and psychotic behavior:
1. The nervous
2. The anxious
3. The sensitive
4. The compulsive
5. The excitable
6. The hyperthymic
7. The depressive
8. The moody
9. The affectively cold
10. The weak-willed
11. The impulsive
12. The sexually perverse
13. The hysterical
14. The fantastic
15. The cranks
16. The eccentric

Most of these statements, though diverse in many respects, revolve about Pinel's description of those

persons who are without "lesion of the understanding, but . . . under the dominance of instinctive and abstract fury, as if the active faculties alone had sustained injury . . . ."[6] and the formulations of Prichard, an English physician. In 1834 Prichard wrote a letter to the father of D. Hack Tuke, inquiring whether cases of "moral insanity" were to be found at the York Retreat: "By that term I distinguish the mental state of persons who betray no lesion of understanding, or want of the power of reasoning and conversing correctly upon any subject whatever, whose disease consists in a perverted state of the feelings, temper, inclinations, habits and conduct."[7] Concerning this statement, Zilboorg says: "Prichard's explanation is the earliest and most precise description of moral insanity."[8] Henderson quotes from Prichard's Treatise on Insanity and Other Defects Affecting the Mind, which was published in London in 1835: "There is likewise a form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested, principally or alone, in the state of the feelings, temper or habits. In cases of this nature, the moral and active principles of the mind are strongly perverted or depraved;

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[6]Quoted in Maughs, ibid.

[7]Quoted by Zilboorg, op. cit., p. 556.

[8]Ibid.

the power of self-government is lost or greatly impaired and the individual is found to be incapable, not of talking or reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life."[9]

It should be kept in mind that much, if not most, of the interest in this topic has stemmed directly from the question of responsibility for crime. Zilboorg mentions briefly one Jerome Cardan, who he said "some years" prior to Johann Weyer (1515-1588) "suggested the concept of what we would call today 'psychopathic personality' or 'irresistible impulse.' One of Cardan's sons did not get along with his wife, and he killed her; he paid the supreme penalty. Cardan proceeded then to argue that certain psychopathies should exempt one from legal responsibility."[10] Such also was the position of Weyer.[11] It is to be noted also that in this country Isaac Ray published his Medical Jurisprudence of Insanity in 1838, three years after Prichard's published formulation of the concept of moral insanity. According to Zilboorg, "The

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[9]D. K. Henderson, Psychopathic States, pp. 11-12.

[10]Zilboorg, op. cit., p. 510

[11]Ibid.

outstanding feature" of this volume by Ray is his "espousal of the theory of moral insanity . . . ."[12]

In England in 1843 there occurred the famous McNaghten case, which Mullins has summarized as follows: " . . . one Daniel McNaghten shot a Mr. Edward Drummond on 20 January 1843, in the belief that Drummond, who was Sir Robert Peel's secretary, was Peel himself. McNaghten cherished a bitter, but unjustified, grievance against Peel. He was tried for murder at the Central Criminal Court by Lord Chief Justice Tindal, sitting with two other judges and a jury. Medical evidence was called for the defence to the effect that McNaghten was of unsound mind at the time of the shooting by reason of morbid delusions. The jury acquitted on this ground. A public outcry followed, . . . The House of Lords decided to make use of an old custom whereby the judges of the High Court can be required to advise the House on general legal principles . . . . Through Lord Chief Justice Tindal the other judges, also somewhat reluctantly, gave their considered answers. The essence of these answers lay in the following statement:

"'The jurors ought to be told in all cases that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crime,

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[12] Ibid., p. 550.

until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.'"[13]

Such a ruling naturally raised the question as to whether "moral insanity" would free a person from responsibility for crime. A related question concerned the "intelligence" of those in this classification. A person who was grossly deficient in intellectual equipment would not "know the nature and quality of the act" or whether "he was doing what was wrong." Some of the authorities maintained that the person who was morally insane suffered from defects of intelligence, but most of the authors cited appear to have argued the question of legal responsibility on other grounds.

Summary. Crime and the concept of psychopathy have enjoyed a long and intimate association. While the authorities do not claim that all criminals are psychopaths or that all psychopaths are criminals, the literature indicates quite clearly that the development of the

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[13]C. Mullins, Crime and Psychology (London: Methuen & Co., Ltd., 1943), pp. 25-26.

concept of psychopathy stemmed directly from concern about the question of responsibility for crime.

The analysis of literature prior to 1935 deals with terminology and the principal characteristics of the condition. Predominating are terms which include the word moral, e. g., "moral insanity" and "moral imbecility." However, the more recent trend has been definitely in the direction of terms like "psychopath" and "psychopathic personality."

The principal characteristics of the condition often vary considerably from author to author. Earlier formulations of the concept were very broad and undoubtedly included conditions which today would be recognized as prepsychotic or psychotic states (notably hypomania) and the neuroses, particularly those of the obsessive-compulsive variety. Furthermore, the authorities studied by Maughs and others do not always agree on symptomatology, etiology, and therapy. Nevertheless, there remains a substantial stratum of agreement among most of the authorities: the condition is different from other forms of mental abnormality; it cannot be explained on the basis of intellectual deficiency; it is something different from willful perversity and criminality; it has serious social consequences; in short, despite the areas of confusion and disagreement, the condition is considered to be something sui generis.

CHAPTER III

METHODOLOGY

This chapter deals with the sources of information upon which this study is based and the methods employed in handling the materials. The two sources of information are: (1) current literature in the field and (2) the results obtained from questionnaires sent by this investigator to key persons in institutions and agencies considered most directly concerned in the matter of dealing with the psychopathic offender. Each of these sources yields considerable information; taken together, they should present evidence as nearly incontrovertible as is possible in a study of this nature.

Methods employed in regard to these sources of information will now be discussed.

Current Literature. For the purposes of the present study, current literature is defined rather arbitrarily as that published during 1935 and since that time. It seems reasonable to assume that the past decade should include adequate representations of such points of view as might properly be termed "current." Literature in the field published during this period has been carefully studied. It is, of course, not claimed that every published article or book relating to the psychopathic

offender is included in the present study. The search, however, for such sources has been intensive, and it is believed that anyone acquainted with the field will recognize that adequately representative sources are included.

It may be granted that no method of analyzing the literature is altogether satisfactory. Particularly is this true when authors approach a subject from varying, and sometimes conflicting, points of view. The fact is, however, that we have to take the authors as we find them.

If any sort of detailed comparative analysis is to be attempted, a preliminary effort must be made in the direction of finding out what the various authors say about specific characteristics of the psychopath. But what are these characteristics? The authors studied do not always cover the same aspects of the problem. The features which seem most significant to one writer often are ignored by another. How is the investigator to proceed?

The method adopted was to put certain questions to the authors _in absentia_. It seemed pertinent to ask, what does each author say about (1) the incidence of this condition, (2) symptomatology (as the basis for diagnosis), (3) etiology, (4) prognosis, and (5) therapy? The results obtained by this method are reported upon in Part Two.

The Questionnaire-Survey. The general scope of the

questionnaire-survey has already been indicated: it was considered necessary to secure information from a representative number of key persons in the institutions and agencies most likely to have professional dealings with the psychopathic offender. The information sought from such persons would concern both concept and practice as outlined previously[1] in the questions to be investigated.

We must now consider these sources of information more specifically. This investigation necessarily deals with several categories of sources. The task would have been much simpler if only one category (such as judges of juvenile courts) had been studied. However, as has already been indicated, the author conceives the present need in terms of a study broad enough to present the general picture of crime control agencies and institutions in their relationship to the psychopathic offender. Even so, it is not maintained that every crime control agency or institution is included in this study, for there must be a limit to the inclusiveness of any investigation. On the other hand, this study includes some sources of information (notably state mental hospitals and departments of welfare) which would not ordinarily be classified primarily as crime control agencies or institutions. The reasons for the inclusion of some agencies and institutions, and the exclusion of others, will be

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[1] In Chapter I.

presently stated.

It is recognized that the exercise of discretion as to sources of information and sampling techniques will introduce a bias into this study. In this case, however, it is believed that the direction and extent of the bias will make the hypotheses more, rather than less, tenable. To illustrate: two of the hypotheses (as stated in Chapter I) maintain that there is a substantial confusion concerning diagnosis and treatment of the psychopathic offender on the part of key persons in institutions or agencies dealing with this individual. In so far as bias does exist in the selection of sources of information and techniques of sampling, it will be in the direction of selecting the most qualified persons or the agencies most likely to be doing superior work. Thus, if confusion or inadequacy exists in the sources selected, it is hardly to be expected that the picture would be any more favorable in regard to any other sources which might have been selected.

The following are the sources from which information was sought through the questionnaires:

Psychiatrists in state mental hospitals
Psychiatrists attached to correctional institutions
Superintendents or wardens of correctional institutions[2]

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[2]Hereafter the term superintendent will be the one used in this connection. The actual titles vary; the administrative heads of juvenile correctional institutions

Directors of state departments of welfare
Judges of juvenile courts
Judges on the circuit court level
Judges on the magistrate court level

After a decision had been reached as to the sources from which information would be sought, the next step was to construct and test questionnaires dealing with the questions raised in Chapter I. These questionnaires were varied slightly according to the groups to which they were sent. Slight variations in terminology were necessary (such as the transposition of words like patient and inmate, trial and hearing) to conform to the usage appropriate for any given situation. The principal difference, however, was that the questionnaires for psychiatrists went more thoroughly into the question of concept. Definitions or descriptions of the psychopath were called for in every instance, inasmuch as it was felt that this would provide one means of determining not only the nature of the concept employed but also whether the person answering the questionnaire was acquainted with the concept itself.

The questionnaires were designed to be filled out with a minimum expenditure of time by those to whom they were sent. Most of the questions included a range of possible answers, in which case all that was necessary

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are generally called superintendents, while both "warden" and "superintendent," and occasionally some other terms, are used for adult institutions.

was the placing of a check mark beside the possibilities listed.

In regard to the question, "What definition or description of the psychopath serves as a guide for diagnosis in your work?" it was necessary to decide whether to allow the answer to be given without any kind of suggestion whatever or whether to list a number of characteristics with the request that those deemed essential to the psychopathic syndrome be checked. The latter procedure would have provided almost surely a greater uniformity of answers and a vastly easier task in tabulating and analyzing. If such a scheme had been followed, some characteristics quite outside the psychopathic syndrome would have been included so as to provide a check on the thoughtfulness and suggestibility of the person giving the answer. Nevertheless, it was felt that any list of characteristics would have been sufficiently suggestive to influence the nature of the answers given. It was, therefore, decided to ask the question and let each one answer in his own words. Such a procedure would make for greater spontaniety in the answers and, it is felt, provide the most accurate picture of the working concept employed.

These questionnaires, and the covering letter, were examined critically by several persons (including a psychiatrist in charge of a state mental hospital, an experienced probation and parole worker, criminologists,

and teachers of sociology) and were refined until one could be reasonably satisfied with their adequacy.

The next step was to make a pilot study. Virginia was chosen for this pilot study principally because it was the state in which the author was living, and this accessibility from the geographic standpoint would make possible conferences or other means of checking on the adequacy of the questionnaires after the initial returns were in.

In this pilot study, sixteen questionnaires were sent out, and answers were received from nine of these. In every case, the answers indicated that the questions were correctly interpreted. It was felt, therefore, that the questionnaires would provide adequate information, and that they would be answered by a sufficient number of persons to make the study significant.

After the pilot study had been completed, questionnaires were sent out on a nation-wide basis. In each instance, the covering letter (a copy of which is given in Appendix B-1) was individually typed. Copies of the questionnaires are shown in Appendix B-2-8.

The sources from which information was sought by means of the questionnaires, and the methods of sampling employed in connection with them, will now be discussed.

Psychiatrists in State Mental Hospitals. This is probably the most important category in the entire study, with the possible exception of the psychiatrists attached to correctional institutions. The importance of this

group from the standpoint of the present study is threefold: (1) Some of these mental hospitals are custodians of the so-called criminal insane. (2) Even when this is not the case, the courts often commit an alleged criminal to such a hospital for a period of observation in order to determine whether or not he is to be considered legally sane. These institutions, therefore, offer important sources of information from the point of view of actual contact with the psychopathic offender. (3) Of considerable importance also is the fact that, generally speaking, knowledge about the concept and recommended methods of handling such cases may be said to originate principally in the psychiatric profession. If the various sources of information may be visualized as constituting a series of concentric circles, the psychiatrists would be at the center of the circle, and the other categories would be distributed between the center and the periphery in the approximate order in which we shall consider them. From the center of this hypothetical circle, information and opinions regarding the psychopath may spread out to the other categories under consideration.

The question may be raised as to why psychiatrists other than those attached to state mental hospitals and correctional institutions are not included in the questionnaire-survey. In answering such a question, it should be pointed out, first of all, that psychopaths

who become entangled with the law have a greater expectation of being seen by psychiatrists attached to state mental hospitals or correctional institutions than by psychiatrists working in private institutions or engaged in private practice. Furthermore, it is to be recognized that many among this latter group of psychiatrists who have a special interest in the subject have written articles or books on the psychopath; hence many of their contributions are included in the study of current literature.

Because of the importance of the state mental hospitals from the standpoint of this study, it was deemed advisable to send one questionnaire to each hospital. The choice of the particular psychiatrist who should receive the questionnaire in any hospital was a rather obvious one. It would seem that the chief medical officer, by whatever title known, should be the recipient of the questionnaire. In the great majority of instances, this person was the superintendent. These names were secured from the List of Fellows and Members of the American Psychiatric Association, 1945. In a few instances, the name of the superintendent was not given, which meant either that the superintendent was not a fellow or member of the association or that the office of superintendent was vacant at that time. Wherever the name of the superintendent was not given, the questionnaire was sent to the person designated as the highest ranking

medical officer, e.g., clinical director. This selection of names may introduce some slight bias to the study in that it eliminated those who are not fellows or members of the American Psychiatric Association, but it is believed the bias would be in the direction of the selection of the most qualified experts in the field.

It was decided, then, to send questionnaires to the chief medical officer in each state mental hospital given in the 1945 List of Fellows and Members of the American Psychiatric Association. This meant one hundred sixty-two questionnaires distributed through forty-five states and the District of Columbia.

Psychiatrists Attached to Correctional Institutions. Much of what has been said in regard to psychiatrists attached to mental hospitals would apply also to those working in correctional institutions, and it would even be reasonable to suppose that those in correctional institutions would have somewhat greater experience with the psychopath who becomesinvolved in criminal proceedings. The number of psychiatrists attached to correctional institutions appears to be relatively small. A careful combing of the List of Fellows and Members of the American Psychiatric Association (as published in 1945) revealed only thirty-eight such persons serving correctional institutions, and nine of these were employed in federal institutions. (A partial explanation of this condition may be that many prison psychiatrists were at this time serving

in the armed forces.) The names of five others were secured from the directory of State and National Correctional Institutions in the United States of America and Canada,[3] bringing the total to forty-three such persons serving correctional institutions in sixteen states, the District of Columbia, and the federal government. It was decided that a questionnaire should be sent to each of those in this category.

Superintendents of Correctional Institutions. Names and addresses of superintendents of correctional institutions, and brief descriptions of the nature of these institutions, were secured from the directory of State and National Correctional Institutions already referred to. It was considered advisable to divide these into adult and juvenile institutions, and to send questionnaires to representatives of each of these groups.

In order to secure adequate representation, it was decided to select one institution for male prisoners and one for female prisoners in each state (and to do this on both the adult and juvenile level) wherever such divisions were made in the state prison systems. In the states where separate institutions are not maintained for male

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[3]It is not altogether certain that these five are psychiatrists; they were listed in this directory (published by the American Prison Association, July 1945) as superintendents, and were further designated as "Dr." or "M.D." It is known, however, that one of those so designated is a psychiatrist, and presumably others may be also.

and female prisoners, only one questionnaire was sent for the adult institution and one for the juvenile.

In regard to the adult correctional institutions, the effort was made to select the "state prison" or "state penitentiary," in contrast to "state farms" or other subsidiary institutions. If two or more prisons seemed to be of the same nature, the one was selected which has a substantially larger population, this being done on the assumption that the one with the substantially larger population would be the principal penitentiary for the state. In a case where such differentiation could not satisfactorily be made, one prison was selected by lot. This procedure was followed for both male and femals institutions.

In addition to the questionnaires sent to the superintendent of state prisons, one questionnaire was sent to the director of the Bureau of Federal Prisons. Altogether, seventy-one questionnaires were sent to administrative heads of adult correctional institutions in forty-eight states, the District of Columbia,[4] and the federal government.

In regard to juvenile correctional institutions, the procedure was slightly more complex. As already stated, it was determined to select one male and one female

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[4]In this study, the District of Columbia is treated as though it were a state.

juvenile institution from each state. A complicating factor was that in some states these institutions were designated as white and colored. Therefore, if the first institution selected (by the method described below) was, for example, white male, then the other selection would be made from the female colored institutions. If all or none of the states had their institutions divided according to race, this specialized kind of selection might have been avoided. The method described would seem to make for a fair distribution on the basis of both race and sex.

The number of questionnaires sent to superintendents of juvenile institutions was eighty-one and the distribution was through forty-seven states, the District of Columbia, and the federal government.

In several instances the superintendents of these institutions were psychiatrists. Wherever this was the case, they were included in the category of psychiatrists attached to correctional institutions. This was done because the questionnaire sent to psychiatrists went more thoroughly into conceptual details.

State Departments of Welfare. These agencies were included because of the information they could provide about juvenile delinquents on a state-wide basis. (In this instance the questionnaire specified, "These questions refer to your work with juvenile delinquents only.)

The exact titles of this agency vary considerably,

such as State Department of Social Security and Welfare (Arizona), State Board of Welfare (Delaware), Department of Social Welfare (Florida), etc. In view of the diversity of titles, this agency will hereafter be referred to simply as state department of welfare.

In each instance, the questionnaire was sent to the director or commissioner or the person who otherwise by his title was indicated to be in charge of this agency (hereafter designated simply as "director"). These names were secured from The Book of the States, 1945-1946 edition.[5]

Judges of Juvenile Courts. The pattern of juvenile court functioning is by no means clear or uniform. One state (Wyoming) has no juvenile court law.[6] Several states have set up special juvenile courts (or, in some instances, courts of domestic relations) but have failed to provide these courts with separate officials. In some states various officials (e.g., judges of the superior court, judges of the probate court, judges of the county court, and clerks of the court) serve ex officio as judges of juvenile courts.[7] Only a few states have uniform

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[5]Chicago: The Council of State Governments, 1945.

[6]Directory of Probation Officers in the United States and Canada (New York: National Probation Association, 1941).

[7]Appendix C-1 shows the names of the courts with which these juvenile courts are combined in the various states.

juvenile courts. A questionnaire was sent to one of the judges in each of these states. The selection was made by the method explained in a later portion of this chapter.

Judges on the Circuit Court and Magistrate Court Level. In considering the courts to which questionnaires should be sent (in addition to the juvenile courts as indicated above), it seemed reasonable to eliminate the highest courts because of the necessary limitation as to the scope of the study and also because it appears that the great majority of criminal cases are settled in the inferior courts. Also, all courts whose jurisdiction is limited to civil matters were excluded. This is not to suggest that psychopaths do not find their way into civil courts, for they may be sued, for example, for breach of contract. The elimination of civil courts was due, rather, to the necessay limitation as to the scope of this study and the apparent fact that psychopaths are more likely to be found on the docket of the criminal courts.

It was decided that consideration should be directed at two levels of functioning in the courts. These are designated as circuit court level and magistrate court level. However, the level at which any given court functions is something which cannot be determined merely by looking at the names of the various courts. The judicial set-up varies so much from state to state in function as well as in name that a study of the judicial systems of the various states was necessary before the determination of

the courts at these two levels of functioning could be made. The source book used for this study of the courts was the 1946 edition of the Martindale-Hubbell Law Directory,[8] which contains an extended section on the names and functions of the various courts in each of the states. In some instances, the names and addresses of judges were also given.

The courts here designated as being on the circuit court level have a great diversity of names,[9] such as circuit court, superior court, court of common pleas, county court, and even supreme court (in New Jersey, where the supreme court justice presides over a circuit, each county constituting a circuit[10]).

A questionnaire was sent to two judges on the circuit court level in each state except Virginia, where five of these judges were included in the pilot study.

The names of courts on the magistrate court level are also exceedingly diverse: county court (in thirteen states), justice court and justice of the peace (sixteen states), trial justice (four states), court of quarter-sessions (one state), court of general sessions (one state), and district court (one state).[11]

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[8]Summit, N. J.: Martindale-Hubbell, Inc.

[9]For a complete listing of these by states, see Appendix C-2.

[10]Martindale-Hubbell, New Jersey Court Calendar.

[11]For a complete list of these by states, see Appendix C-3.

The question may be raised as to why a district court should be put in this magistrate court classification. This instance (Rhode Island) provides an illustration of the diversity of function of the various courts. The courts of this state are a supreme court, a superior court, district court, and justices of the peace. However, "justices of the peace have no authority to act as judges...."[12] Hence the selection of the district court in this instance.

It is not claimed that the courts selected at this level are completely homogeneous, but rather that the selection made contains as much homogeneity as the varying judicial systems make possible.

A questionnaire was sent to one judge on the magistrate court level in each state. However, in actuality the sample is somewhat larger because several of the juvenile court judges (in the forty-six states having juvenile courts of the combined or ex officio variety) are primarily judges on the magistrate court level.

When the names and addresses of judges were not given in the directories already cited, this information was generally secured from other directories (such as "blue books" and "rosters") published by the various states. When these were out of date or not available or did not contain all the information needed, letters were written to the various secretaries of state requesting the desired

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[12]Martindale-Hubbell, Rhode Island Court Calendar.

information. In the very few instances in which complete information regarding name and address was not gained by these various methods, it was necessary to address the letter simply by title -- e.g., Judge of the Municipal Court, city and state.

Other Details of Sampling. In regard to several of the above categories of information it has been pointed out that selections had to be made between two or more sources. The method employed in making these selections will now be discussed.

In every case where numbers greater than five were involved, the Fisher and Yates table of random numbers[13] was employed. When the size of the universe was five or under, the following procedure was followed: when only two choices were involved, the selection was made by tossing a coin; when the size of the universe was between three and five, the selection was made by drawing small numbered cards from a box.

Summary of Questionnaires Sent and Answered. Answers were received from three hundred twenty-six of the six hundred twenty questionnaires sent out. Table 1 summarizes this situation by sources of information.

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[13] R. A. Fisher and F. Yates, Statistical Tables for Biological, Agricultural and Medical Research, as given in E. F. Lindquist, Statistical Analysis in Educational Research (Boston: Houghton Mifflin Company, 1940).

TABLE 1. OVERALL SUMMARY OF DISTRIBUTION OF QUESTIONNAIRES

Source of Information	Number Sent Out	Number Answered
Psychiatrists in state mental hospitals	162	95
Psychiatrists attached to correctional institutions	43	24
Superintendents of juvenile correctional institutions	81	45
Superintendents of adult correctional institutions	71	34
Directors of state departments of welfare	48	33
Judges of independent juvenile courts	22	16
Judges of combined juvenile courts	46	16
Judges on circuit court level	99	44
Judges on magistrate court level	48	19
Totals	620	326

We consider now the geographical distribution of these questionnaires. Table 2 summarizes the distribution among psychiatrists in state mental hospitals. Here it is seen that one hundred sixty-two questionnaires were sent to psychiatrists in forty-five states (all states except Nevada, New Mexico, and Wyoming) and the District of Columbia. Answers were received from thirty-eight states --

all states to which the questionnaires were sent except Florida, Georgia, Mississippi, North Carolina, South Carolina, Vermont, West Virginia, and the District of Columbia.

TABLE 2. DISTRIBUTION OF QUESTIONNAIRES AMONG PSYCHIATRISTS IN STATE MENTAL HOSPITALS

State	Number Sent Out	Number Answered	State	Number Sent Out	Number Answered
1.Ala.	1	1	26.Nev.	0	0
2.Arizona	1	1	27.N.H.	1	1
3.Ark.	1	1	28.N.J.	3	2
4.Calif.	9	6	29.N.M.	0	0
5.Col.	2	1	30.N.Y.	15	11
6.Conn.	3	3	31.N.C.	3	0
7.Del.	1	1	32.N.D.	1	1
8.Fla.	1	0	33.Ohio	8	8
9.Ga.	1	0	34.Okla.	4	3
10.Idaho	1	1	35.Ore.	2	1
11.Ill.	11	6	36.Penn.	15	7
12.Ind.	5	3	37.R.I.	1	1
13.Iowa	3	1	38.S.C.	1	0
14.Kan.	3	1	39.S.D.	1	1
15.Ky.	3	1	40.Tenn.	2	1
16.La.	2	1	41.Texas	4	1
17.Maine	2	2	42.Utah	1	1
18.Md.	4	2	43.Vt.	1	0
19.Mass.	14	8	44.Va.	4	2
20.Mich.	4	2	45.Wash.	3	2
21.Minn.	4	3	46.W.Va.	4	0
22.Miss.	1	0	47.Wisc.	2	1
23.Mo.	4	3	48.Wyo.	0	0
24.Mont.	1	1	49.D.C.	1	0
25.Neb.	3	2			

SUMMARY:
Number of questionnaires sent out -- 162 in 45 states and D. C.
Number of questionnaires answered -- 95 in 38 states

Table 3 shows the geographical distribution of questionnaires for all correctional institutions. Of the one

hundred ninety-five questionnaires sent to superintendents of correctional institutions (adult and juvenile) and psychiatrists attached to these institutions, one hundred three were answered. For superintendents of adult correctional institutions, seventy-one questionnaires were sent to forty-eight states, the District of Columbia, and federal institutions; thirty-four answers came from twenty-eight states, the District of Columbia, and federal institutions. The superintendents of juvenile correctional institutions received eighty questionnaires in forty-seven states, the District of Columbia, and federal institutions; the forty-five answers came from thirty-six states and the federal government. Forty-three psychiatrists attached to correctional institutions in sixteen states, the District of Columbia, and the federal government received questionnaires; the twenty-five answers represent eleven states, the District of Columbia, and the federal government.

When these three categories are considered together, it is seen that institutions in all forty-eight states, the District of Columbia, and the federal government received questionnaires, and that answers came from all these except Arizona, Louisiana, Mississippi, New Mexico, Rhode Island, South Carolina, and Texas.

TABLE 3. DISTRIBUTION OF QUESTIONNAIRES AMONG CORRECTIONAL INSTITUTIONS

State	Superintendents				Psychiatrists	
	Adult Instit.		Juvenile Instit.			
	Number Sent	Number Ans.	Number Sent	Number Ans.	Number Sent	Number Ans.
1. Ala.	2	1	1	1	1	0
2. Arizona	1	0	1	0	0	0
3. Ark.	2	2	2	0	0	0
4. Calif.	2	1	2	2	0	0
5. Col.	1	1	2	1	0	0
6. Conn.	2	1	2	1	1	1
7. Del.	1	1	2	0	0	0
8. Fla.	1	1	2	1	0	0
9. Ga.	1	1	2	0	0	0
10. Idaho	1	1	1	1	0	0
11. Ill.	1	0	2	2	2	2
12. Ind.	2	1	2	2	1	1
13. Iowa	2	1	2	1	0	0
14. Kan.	2	2	2	2	0	0
15. Kentucky	2	0	1	1	0	0
16. La.	1	0	2	0	0	0
17. Maine	2	1	2	1	0	0
18. Md.	2	0	2	1	3	0
19. Mass.	1	0	2	1	4	3
20. Mich.	2	0	2	1	4	2
21. Minn.	2	1	2	1	1	1
22. Miss.	1	0	1	0	0	0
23. Mo.	1	0	2	1	0	0
24. Mont.	1	0	1	1	0	0
25. Neb.	2	2	2	1	0	0
26. Nev.	1	1	1	0	0	0
27. N. H.	1	1	1	1	1	0
28. N. J.	2	1	2	1	0	0
29. N. M.	1	0	2	0	0	0
30. N. Y.	2	1	2	1	8	2
31. N. C.	2	1	2	2	0	0
32. N. D.	1	0	1	1	0	0
33. Ohio	2	1	2	2	0	0
34. Okla.	1	0	1	1	0	0
35. Oregon	1	0	1	1	0	0
36. Penn.	2	2	1	1	2	2
37. R. I.	1	0	2	0	0	0
38. S. C.	1	0	2	0	0	0
39. S. D.	1	1	1	1	0	0
40. Tenn.	1	0	2	0	1	1
41. Texas	1	0	0	0	1	0
42. Utah	1	0	1	1	0	0
43. Vt.	2	1	1	1	1	1
44. Va.	1	1	2	2	1	1
45. Wash.	1	1	2	1	0	0
46. W. Va.	1	0	2	1	0	0
47. Wisc.	2	1	2	1	1	0
48. Wyo.	1	0	2	2	0	0
49. D. C.	2	2	1	0	1	1
Federal	1	1	1	1	9	6
Totals	71	34	81	45	43	24

Table 4 shows the distribution of questionnaires among the state departments of welfare. One questionnaire was sent to each state, and answers came from thirty-three of these.

TABLE 4. DISTRIBUTION OF QUESTIONNAIRES AMONG STATE DEPARTMENTS OF WELFARE

State	Number Sent	Number Ans.	State	Number Sent	Number Ans.
1. Ala.	1	1	25. Neb.	1	1
2. Ariz.	1	1	26. Nev.	1	1
3. Ark.	1	0	27. N. H.	1	1
4. Calif.	1	0	28. N. J.	1	0
5. Col.	1	1	29. N. M.	1	1
6. Conn.	1	0	30. N. Y.	1	1
7. Del.	1	0	31. N. C.	1	1
8. Fla.	1	1	32. N. D.	1	0
9. Ga.	1	0	33. Ohio	1	1
10. Idaho	1	1	34. Okla.	1	0
11. Ill.	1	1	35. Ore.	1	1
12. Ind.	1	0	36. Penn.	1	0
13. Iowa	1	1	37. R. I.	1	0
14. Kan.	1	0	38. S. C.	1	0
15. Ky.	1	1	39. S. D.	1	1
16. La.	1	1	40. Tenn.	1	1
17. Maine	1	1	41. Texas	1	1
18. Md.	1	1	42. Utah	1	1
19. Mass.	1	1	43. Vt.	1	1
20. Mich.	1	1	44. Va.	1	1
21. Minn.	1	1	45. Wash.	1	1
22. Miss.	1	1	46. W. Va.	1	1
23. Mo.	1	1	47. Wisc.	1	1
24. Mont.	1	0	48. Wyo.	1	0

SUMMARY:
Number of questionnaires sent out -- 48 (one to each state)
Number of questionnaires answered -- 33

Table 5 shows the distribution of questionnaires among the various courts. Of two hundred fifteen question-

naires sent to the judges of juvenile courts (independent and combined), judges on the magistrate court level, and judges on the circuit court level, ninety-five were answered. The highest percentage of answers came from the independent juvenile courts (sixteen out of twenty-two answered), while the lowest percentage of answers came from the combined juvenile courts (sixteen out of forty-six answered).

When all courts are considered together, it is seen that answers came from all states except California, New Mexico, Vermont, Wisconsin, and Wyoming.

The summaries which we have just been considering represent the distribution of questionnaires in terms of the institutions and agencies to which they were sent. Generally speaking, the questionnaires were answered by the persons to whom they were sent, or at least by someone occupying a closely related position. For example, some of the questionnaires sent to directors of state departments of welfare were answered by administrative personnel in such subdivisions of this department as child welfare or foster care. It would not seem that such minor variations in answers are of enough significance for this study to make individual notations concerning the title of the person answering. In some instances, however, the questionnaires were answered by others occupying a sufficiently different position to warrant a special notation, even though their work is in the department of

TABLE 5. DISTRIBUTION OF QUESTIONNAIRES AMONG ALL COURTS

State	Juvenile Courts				Magistrate Ct. Level		Circuit Ct. Level	
	Ind.		Combined					
	Num. Sent	Num. Ans.	Num. Sent	Num. Ans.	Num. Sent	Num. Ans.	Num. Sent	Num. Ans.
1. Ala.	1	0	1	0	1	0	2	1
2. Ariz.	0	0	1	0	1	0	2	2
3. Ark.	0	0	1	0	1	0	2	1
4. Calif.	0	0	1	0	1	0	2	0
5. Col.	1	1	1	1	1	0	2	2
6. Conn.	1	0	0	0	1	0	2	1
7. Del.	1	1	1	1	1	1	2	1
8. Fla.	1	1	1	0	1	0	2	2
9. Ga.	1	0	1	1	1	1	2	1
10. Idaho	0	0	1	0	1	1	2	1
11. Ill.	1	0	1	1	1	1	2	2
12. Ind.	1	1	1	0	1	0	2	0
13. Iowa	0	0	1	0	1	1	2	1
14. Kansas	0	0	1	1	1	1	2	0
15. Ky.	0	0	1	0	1	0	2	1
16. La.	1	1	1	0	1	0	2	2
17. Maine	0	0	1	0	1	0	2	2
18. Md.	1	1	1	1	1	0	2	1
19. Mass.	1	0	1	1	1	1	2	0
20. Mich.	1	1	1	0	1	1	2	1
21. Minn.	0	0	1	1	1	1	2	1
22. Miss.	0	0	1	0	1	1	2	0
23. Mo.	0	0	1	0	1	1	2	1
24. Montana	0	0	1	0	1	1	2	0
25. Neb.	0	0	1	1	1	1	2	2
26. Nev.	0	0	1	0	1	1	2	2
27. N. H.	0	0	1	0	1	0	2	1
28. N. J.	1	1	1	1	1	0	2	0
29. N. M.	0	0	1	0	1	0	2	0
30. N. Y.	1	1	1	1	1	0	2	0
31. N. C.	1	0	1	0	1	1	2	0
32. N. D.	0	0	1	0	1	1	2	2
33. Ohio	1	1	1	0	1	0	2	2
34. Okla.	0	0	1	0	1	1	2	0
35. Oregon	0	0	1	2	1	0	2	1
36. Penn.	1	1	1	0	1	0	2	1
37. R. I.	0	0	1	0	1	0	2	2
38. S. C.	1	1	1	0	1	0	2	0
39. S. D.	0	0	1	0	1	0	2	2
40. Tenn.	1	1	1	0	1	0	2	1
41. Texas	0	0	1	1	1	0	2	0
42. Utah	1	1	0	0	1	0	2	0
43. Vt.	0	0	1	0	1	0	2	0
44. Va.	1	1	1	0	1	0	5	2
45. Wash.	0	0	1	1	1	1	2	1
46. W. Va.	1	1	1	1	1	1	2	1
47. Wisc.	0	0	1	0	1	0	2	0
48. Wyo.	0	0	1	0	1	0	2	0
Totals	22	16	46	16	48	19	99	44

the persons to whom the questionnaires were sent. In Appendix E identifying notations are provided to indicate significant variations in the position or title of the person answering any given questionnaire.

The distribution of returned questionnaires will now be summarized in terms of the position or title of the persons answering them.

In the category psychiatrists in state mental hospitals all answered questionnaires came from psychiatrists in the respective institutions.

Under the heading psychiatrists in correctional institutions twenty-four of the questionnaires were answered by those to whom the questionnaires were sent. In addition, six other psychiatrists answered the questionnaires which had been sent to the superintendents of their respective institutions. The only satisfactory method of handling this situation seemed to be to place these six in the category of psychiatrists in correctional institutions, increasing to thirty the number subsequently studied under this heading. It is possible that four of these thirty are not psychiatrists: three indicated that they were prison physicians and another (also an "M.D.") is a commissioner of state institutions who reported on a state prison. Whether these four are psychiatrists as well as physicians is not known. However, it is evident from their answered questionnaires that they are acquainted with psychiatric concepts, and

it seems reasonable to include them in the psychiatric category. One of the thirty in the psychiatric category is the director of the behavior clinic of the criminal court in a large metropolitan area and so, strictly speaking, is not attached to a correctional institution; but the nature of his responsibility is so similar to that of the other psychiatrists in this category that he is included.

Forty-five answers came from juvenile correctional institutions. One of these answers was signed by the administrative assistant, and another by the chief clerk. However, these two occupy positions sufficiently similar to the superintendent to make it wise to consider their answers along with those of the superintendents of other correctional institutions. On the other hand, six of the forty-five answers came from psychologists, and one came from a psychiatrist. Therefore, for purposes of analysis the number of superintendents of juvenile correctional institutions will be placed at thirty-eight.

Answers came from thirty-four of the adult correctional institutions, one of these being signed by the general accountant, whose answer is considered along with those of the superintendents. Five of the thirty-four answers came from psychiatrists, and two from psychologists, thus reducing the number of answers from superintendents to twenty-seven.

As has already been explained, these psychiatrists

who answered the questionnaires sent to the superintendents of their respective institutions are considered in connection with the category of psychiatrists in correctional institutions. The psychologists who answered the questionnaires sent to the superintendents of their institutions (a total of eight) are placed in a category of their own.

Questionnaires sent to state departments of welfare were answered by the directors of these departments (or by someone in a closely related position) except in the following instances: one questionnaire was answered by the executive psychologist, State Bureau of Juvenile Research; another was answered by the director of the division of mental hygiene (an "M.D." and presumably a psychiatrist); another was answered by the chairman of the Juvenile Institute Commission; another was answered by the state psychiatrist; and still another was answered by the psychiatrist in the Institute for Juvenile Research. Several of the directors replied to the effect that their departments had no jurisdiction in cases of juvenile delinquency. One of these referred the questionnaire to the chief probation officer of the juvenile court "which serves more children than any other one juvenile court department in the state." This questionnaire was subsequently answered by the probation officer in the court referred to, and has been handled in this study under the heading of combined juvenile courts. However, in no other

instances were the returned questionnaires transferred to other categories, inasmuch as the persons answering were speaking for the departments of welfare.

All questionnaires from independent juvenile courts were answered by the judges except as follows: four were answered by the chief probation officers, one by the director of the court, one by the administrative assistant to the court, one by the director of the court's psychiatric clinic, and one by the register of the juvenile court.

Probation officers answered three of the questionnaires received from combined juvenile courts. All others were answered by the judges.

On the circuit court level all answers came from judges except in one case, where it was the solicitor general who replied.

All answers on the magistrate court level came from the judges.

The answers from all questionnaires have been tabulated and are presented in complete form, question by question, in Appendix E. The complete results are so voluminous that only summary tables, and occasionally some of the more detailed information, can be given in the main body of the text. The answers in Appendix E are numbered in such a way that any questionnaire can be reconstructed question by question, without, however, revealing the identity of the person from whom it came. By this means the raw materials of this study are made available for any

others who may wish to check the results or conduct further investigations.

This chapter has presented the methodology employed in conducting the research upon which this study is based. After a brief consideration of methods used in connection with the investigation of current literature, the remainder of the chapter dealt with the questionnaire-survey. This has been done in considerable detail so that each reader may judge for himself the significance of the results obtained.

PART TWO

THE PRESENT STATUS OF CONCEPT AND PRACTICE AS INDICATED BY CURRENT LITERATURE AND THE QUESTIONNAIRE-SURVEY

CHAPTER IV

EXTENT OF ACQUAINTANCE WITH THE CONCEPT

This chapter deals with conceptual acquaintance on a very elementary level. In later chapters we shall explore conceptual nuances; but at present we want to discover the extent to which there is even bare or minimal knowledge of what a psychopath is. We want to find out whether certain key persons recognize that authorities consider psychopathy to be a separate category of mental disorder, or whether the term is equated with "insanity" or mental illness in general, or whether the term evokes any response whatever.

It is unnecessary in this connection to make more than a brief reference to current literature. It is self-evident that the authors who discuss such aspects of the condition as incidence (Chapter V), symptomatology (Chapter VII), etiology (Chapter IX), prognosis and therapy (Chapter XI) have at least a minimal acquaintance with the concept. The emphasis of this chapter, therefore, will be upon the material gathered through the question-

naire-survey.

In attempting to determine minimal conceptual acquaintance, it is usually necessary to consider each questionnaire as a whole. Nevertheless, some sections of the questionnaire are particularly indicative of the extent of conceptual acquaintance. These will now be discussed briefly.

All questionnaires except those sent to psychiatrists and to superintendents of correctional institutions included the question, "In your work, do you use the classification of 'psychopath' or some similar term?"[1] On every questionnaire was the instruction, "If there is some other similar term which you use instead of 'psychopath,' please give that term here _____, and substitute that term for the term 'psychopath' in the questions below."[2]

If someone answers that he does not use the term psychopath, and if he neither gives some similar term used nor makes some further qualifying statement, it may be presumed that he is lacking in minimal acquaintance with the concept. On the other hand, if he states that the similar term used is such a term as "mental case" or

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[1]The complete answers to this question are given in Appendix E-1.

[2]Answers are given in Appendix E-1 and E-8.

"insanity," it may also be presumed that he is unacquainted with the concept.

Another topic in every questionnaire was this: "What definition or description of the psychopath serves as a guide for diagnosis in your work?"[3] Unfortunately, this question was not always answered, but such answers as were given supply additional illumination on the question of conceptual acquaintance.

In a few instances the reported percentage of psychopaths coming before a court or appearing in a correctional institution may serve to indicate the extent of conceptual acquaintance. Whenever a percentage approaching zero is reported, we may reasonably suspect that knowledge about the psychopath is also near zero.

In examining the questionnaires for elementary knowledge of the concept, the procedure will be to say that minimal conceptual acquaintance is proved to be lacking only when those answering the questionnaire definitely indicate their ignorance of the concept in one or more of the ways just discussed, rather than to assume ignorance unless knowledge is proved. This procedure will be followed in order that any error in this investigator's interpretation may be in the direction of giving the benefit of doubt to those answering the questionnaires.

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[3]Answers are given in Appendix E-8.

The psychiatrists reported upon in the questionnaire-survey constitute the first group to consider in this connection. It will be recalled that the questionnaire was answered by ninety-five psychiatrists in state mental hospitals and by thirty psychiatrists serving correctional institutions. An examination of these answered questionnairos reveals no evidence of ignorance of the concept at the level now being discussed. Indeed, the evidence strongly indicates that all these psychiatrists possess at least minimal conceptual acquaintance.

These same statements apply for the eight questionnaires answered by psychologists attached to correctional institutions.

We consider next the superintendents of juvenile correctional institutions. Of the thirty-five wardens and superintendents answering the questionnaire, the following appear to lack minimal conceptual acquaintance:

The superintendent of an industrial school for girls writes as her answer to the questionnaire: "We do not attempt to Psychoanalize [sic] any of our students. If we have an idea that they are in need of this treatment we send them to the _____ _____ Hospital and they make the recommendations."

Another superintendent writes that there are no psychopaths in her institution, since "We have only delinquents or incorrigible . . . ." Is it conceivable that

no psychopaths would be found among those described as delinquent or incorrigible?

Another superintendent also reports no psychopaths, but says that if one does show up "she is generally sent to one of our state hospitals for observation and X-Rays . . . . and if the girl is mentally ill, she is kept in a psychopathic hospital." In this case it appears rather definite that psychopathy is not distinguished from other forms of mental abnormality.

Another also reports no psychopaths, saying they are to be found at the state hospital.

Another regrets that the questions cannot be answered because "we do not have a psychistrist [sic] in this institution . . . . "

Another definitely equates psychopathy with psychosis.

Another gives this definition: "An emotionally unstable personality, characterized by traits of mental disease."

In addition to these seven out of thirty-five who appear definitely to lack minimal conceptual acquaintance, there are five others who probably should be so classified.

We consider now the questionnaire returns from the twenty-nine superintendents of adult correctional institutions. The following instances appear to lack minimal conceptual acquaintance:

The warden of a state penitentiary gives this definition: "When a persons reaction is markedly differ-

ent than his normal reaction to his surroundings." To be considered with this definition is his report of a zero percentage of psychopaths in his institution.

Another's description of the condition is "General lack of mental stability."

The superintendent of a women's reformatory reports a zero percentage of psychopaths, gives no definition or description, and states that no diagnosis is made.

Another superintendent states that no diagnosis is made, and gives this definition: "A person who exhibits signs of suffering from a mental disease."

The only information given by another is that "All mental cases are transferred to _____ State Hospital for treatment."

Thus it appears that five out of the twenty-nine definitely lack even minimal conceptual acquaintance. It is highly probable that seven others should be so classified, but the information given on their returned questionnaires is too meager to allow one to make a definite judgment in this respect.

Thirteen of the thirty-three state departments of welfare reported that they do not use the term psychopath or some similar term, but six of these presented additional information which indicated possible or probable knowledge of the concept. Seven apparently lack minimal conceptual acquaintance.

The answers from the sixteen independent juvenile

courts will now be considered. Five of these sixteen reported that they do not use the term psychopath or some similar term. Two of these, however, clearly indicated knowledge of the concept; hence the number would be reduced to three. On the other hand, of those reporting the term used, one equated it with psychosis, and another showed complete ignorance of the condition. Thus it appears that five out of sixteen definitely lack minimal conceptual acquaintance.

Six of the sixteen combined juvenile courts report the term not used. Of those who do report the term used, two equate psychopathy with psychosis, one refers to "mental unsoundness," another's definition is "mentally ill," and another gives "mental case" as the similar term used. Hence eleven of the sixteen may be said to lack minimal conceptual acquaintance.

We turn next to the forty-four replies from judges on the circuit court level. Twenty-six of these reported the term not used. However, for one of these an accompanying letter clearly indicates knowledge of and concern about psychopathy; hence the number should be reduced to twenty-five. On the other hand, among those stating that the term is used, one defines the condition as "insanity," another states the similar term used is "mental incompetent," and still another "mentally defective." Therefore, evidence is present to indicate that twenty-eight out of

the forty-four lack minimal conceptual acquaintance.

Nineteen replies were received from judges on the magistrate court level. Of these, eight reported that they did not use the term. Two others gave these definitions: "I have none. Each case on its own merits." "Havent used any thus far." These definitions considered in their context make it quite clear that at least ten of the judges on the magistrate court level lack minimal conceptual acquaintance.

In presenting material of this sort as evidence of lack of awareness of the concept of psychopathy, due regard must be given to possible misinterpretations of the question. It is possible, of course, that some are aware of the concept, but do not use it in their work on account of the way in which their particular classification systems may be set up. However, the returned questionnaires and accompanying letters were examined carefully for any qualifying data. The statement that the term psychopath was not used was accepted as evidence of lack of conceptual awareness only in those instances where such a reply was thoroughly consonant with the rest of the questionnaire.

Summary. The returned questionnaires have been examined for extent of minimal conceptual acquaintance. For the purpose of this chapter, minimal acquaintance is said to be lacking only when those answering the questionnaires

furnish definite proof of their ignorance in this respect. The results are summarized in Table 6.

TABLE 6. LACK OF MINIMAL CONCEPTUAL ACQUAINTANCE

Source of Information	Number Answering Questionnaire	Number Indicating Lack of Minimal Conceptual Acquaintance	Percentage Indicating Lack of Minimal Conceptual Acquaintance
Psychiatrists in state mental hospitals	95	0	0%
Psychiatrists attached to correctional institutions	30	0	0%
Psychologists attached to correctional institutions	8	0	0%
Superintendents of juvenile correctional institutions	35	7	20%
Superintendents of adult correctional institutions	29	5	17%
State departments of welfare	33	7	21%
Independent juvenile courts	16	5	31%
Combined juvenile courts	16	11	69%
Circuit courts	44	28	64%
Magistrate courts	19	10	52%

It should not be inferred that conceptual acquaintance exists unless the contrary is proved; quite the reverse would be true in many instances. If the questionnaires had been examined only from the point of view of positive evidence for conceptual acquaintance, a far different picture would be the result in most instances.

It must be remembered that some questionnaires present neither positive nor negative information sufficiently definite to make an accurate judgment on extent of conceptual acquaintance, and for that reason extreme care should be exercised in making any inferences from the data given in Table 6. It would be quite misleading, for example, to use this table as a basis for ranking the various sources of information in terms of their knowledge of the concept. It may be pointed out, however, that the psychiatrists and psychologists reported upon in this study show almost universal positive evidence of minimal conceptual acquaintance. At the other extreme, only two judges on the circuit court level can be said definitely to prove such acquaintance; and on the magistrate court level the most that can be said positively is that only one judge indicates even <u>possible</u> minimal acquaintance with the concept here being discussed.

We may now consider the data of this chapter from the point of view of relevance to the hypotheses stated in Chapter I. One hypothesis states: Authorities in the field are in general agreement that the psychopathic offender is materially "different" from other kinds of law-violators -- different from other kinds of mentally abnormal offenders as well as different from those who are considered not mentally abnormal. This has already been shown to be true for the authorities represented in current literature. The analysis presented in this chapter would

indicate that it is true also for such authorities as are represented among psychiatrists in state mental hospitals and psychiatrists and psychologists attached to correctional institutions.

Another hypothesis states: Many "key" persons in agencies and institutions entrusted with the responsibility for crime control are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. We have dealt in this chapter with such key persons as judges (on the juvenile court, circuit court, and magistrate court levels), directors of state departments of welfare, and superintendents of juvenile and adult correctional institutions. If many of these persons do not possess even a minimal conceptual acquaintance, it must necessarily be said that they are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. The lack of minimal conceptual acquaintance on the part of many key persons in crime control agencies and institutions has been demonstrated in this chapter. Therefore, it would seem that this hypothesis should stand as stated.

CHAPTER V

REPORTED INCIDENCE OF THE PSYCHOPATHIC OFFENDER

The task before us in this chapter is to examine the reported incidence of the psychopathic offender. This will be done for current literature and for the questionnaire-survey.

Incidence Reported in Current Literature. The literature is lacking in a systematic attempt to determine the percentage of psychopathic offenders. Some authorities give general estimates; others report upon groups which are hardly representative of the criminal population; many others leave this aspect of the problem untouched.

Healy writes that he is "convinced that a very considerable proportion of the most difficult recidivists present the characteristics of this group."[1] Reckless cites surveys of jails and penal institutions and calls attention to the fact "that the percentage of inmates diagnosed as psychopathic range from 3 to 45.3 . . . . "[2] Sutherland calls

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[1]William Healy, "The Psychiatrist Looks at Delinquency and Crime," The Annals of the American Academy of Political and Social Science, vol. 217 (Sept. 1941), p. 74.

[2]Walter C. Reckless, Criminal Behavior (New York and London: McGraw Hill Book Company, inc., 1940), p. 210.

attention to reports of New York and Massachusetts institutions which "show about 10 per cent of the incoming criminals to be psychopathic personalities, while reports from Illinois institutions generally show more than 75 per cent to be psychopathic personalities, and in fact 88.3 per cent of all offenders admitted to the Illinois Reformatory during the period 1919-1929 were so diagnosed."[3]

Schilder reports on the Clinic of the Court of General Sessions, New York City, for the year 1937. Of a total of 2,698, one hundred ninety-seven (7.3%) were diagnosed as having psychopathic personalities.[4] Bromberg and Thompson, reporting on the 9,958 cases coming before the same court for the four years prior to 1937, found 6.9% diagnosed as psychopathic personalities.[5] This percentage is in contrast to 2.4% found to be mentally defective, 1.5% psychotic, and 6.9% (of 7,100 cases studied) neurotic.[6]

In a report which has the advantage of the diagnoses

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[3]Edwin H. Sutherland, Principles of Criminology (Chicago, Philadelphia, New York: J. B. Lippincott Co., 1939), p. 110.

[4]Paul Schilder, "The Cure of Criminals and Prevention of Crime," Journal of Criminal Psychopathology, vol. 2, no. 2 (Oct. 1940), p. 152.

[5]Walter Bromberg and Charles B. Thompson, "The Relation of Psychosis, Mental Defect and Personality Types to Crime," Journal of Criminal Law and Criminology, vol. 28, no. 1 (May-June 1937), p. 75.

[6]Ibid., p. 78.

actually having been made by the investigator, J. G. Wilson found 17.3% of the inmates at the reformatory for women at Clinton, New Jersey, to be psychopathic.[7] This study was made of the entire population (427) from June 2, 1941, to August 31, 1942. Wilson compares this with the results of a study which he had made in 1936 of 1,000 unselected male inmates at the federal penitentiary, Lewisburg, Pennsylvania, 14% of whom were found to be psychopathic.[8]

Silverman, in a study of the records of 500 male psychotics at the Medical Center for Federal Prisoners, Springfield, Missouri, from 1937 to 1941 finds that schizophrenia (47.4%) was the most important category.[9] However, he discovered psychosis with psychopathic personality to be "the second most important diagnostic group," with 15% of the patients falling in this category.[10] He also reports that in other studies Webster has found 34.4% in this category, and Pinto de Toledo 32.6%.[11]

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[7]J. G. Wilson, "The Female Psychopath," Proceedings American Prison Association, 1942, p. 155.

[8]Ibid.

[9]Daniel Silverman, "Psychoses in Criminals: A Study of Five Hundred Psychotic Prisoners," Journal of Criminal Psychopathology, vol. 4, no. 4 (April 1943), p. 705.

[10]Ibid., p. 707

[11]Ibid., p. 707

Data from mental hospitals also have some bearing on the question, inasmuch as offenders are sometimes confined in such hospitals -- either while being kept under observation or when committed after having been adjudged "insane." Dayton has studied the diagnoses of 65,878 first admissions to Massachusetts mental hospitals for the years 1917-1933. In the classification of psychopathic personality with mental disorder he found a total of 531, or .8%, this condition ranking sixteenth in twenty-one categories. For the diagnosis "psychopathic personality without mental disorder" he found that the condition was second out of seven categories (with the first category being "no associated condition"), representing 1,715 cases, or 2.6%, of all persons diagnosed as being without mental disorder.[12]

Cleckley gives the breakdown of categories for a psychiatric hospital operated by the Veterans Administration. Of eight hundred fifty-seven new admissions occurring between February 9, 1935, and June 12, 1937, one hundred two were diagnosed psychopathic personalities. This condition was third in the list of neurologic and mental disorders, being preceded only by dementia praecox

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[12] Neil A. Dayton, New Facts on Mental Disorders: Study of 89,190 Cases (Springfield, Ill., and Baltimore: Charles C. Thomas, 1940).

and dementia paralytica.[13] However, as he points out, this appears not to represent the total picture, since "It is not customary to make the diagnosis of psychopath unless the condition is pronounced and inescapable, the intention being to spare veterans whenever possible the stigma that is felt by some to go with this term."[14] His own "frank opinion"[15] is that "266 cases, more than one-quarter of the total, undoubtedly represent in various degree the type of character inadequacy and personality disorder which is the object of the present discussion."[16] If his judgment in this respect is to be accepted, then it appears that the psychopathic personality heads the list of all categories in the hospital upon which he is reporting.

In a mental hospital which is more likely to reflect the condition as it exists among the general population, Fox reports on the 972 patients admitted to the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital between January, 1936, and January, 1940. Of these,

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[13] Hervey Cleckley, The Mask of Sanity: An Attempt to Reinterpret the So-Called Psychopathic Personality, (St. Louis: The C. V. Mosby Co., 1941), p. 25.

[14] Ibid., p. 28.

[15] Ibid., p. 27.

[16] Ibid., p. 30.

sixty-eight (or 6.9%) were diagnosed as being cases of psychopathic personality.[17]

Curran has studied all cases admitted to the adolescent ward of Bellevue Hospital during the first three years of the operation of that department. Out of 1,626 cases, he has found one hundred thirty-one (8.05%) diagnosed as psychopathic personalities.[18]

Incidence Reported in the Questionnaire-Survey. The question called for the percentage of cases diagnosed as psychopathic during the year 1945. It was further requested that figures for the latest available year be given if information regarding the year 1945 was not available, and that the year on which the data were based (if other than 1945) be given. In the case of questionnaires going to psychiatrists working in state mental hospitals, the question called for the percentage "diagnosed as psychopathic without psychosis" and the percentage "diagnosed as psychopathic with psychosis." (This breakdown into percentage with and without psychosis is in line with the statistical data kept by these hospitals.)

Appendix E-2 contains the individual reports of those

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[17]Henry Fox, "Dynamic Factors in the Affective Psychoses," American Journal of Psychiatry, vol. 98 (March 1942), p. 685.

[18]Frank J. Curran, "A Statistical Study of Adolescent Delinquents in Bellevue Hospital," Journal of Criminal Psychopathology, vol. 3 (July 1941), p. 37.

answering this question. We shall now analyze the results, beginning with psychiatrists attached to state mental hospitals.

Table 7 shows the incidence of psychopathy which these psychiatrists report for the hospitals with which they are associated. In this table the percentages reported are for psychopaths both with and without psychosis, inasmuch as it is the total percentage of psychopaths which is of significance for this study. However, for whatever significance it may have, it may be pointed out that there is no definite pattern as to the predominance of one of these categories over the other. Of ninety-five questionnaires from these psychiatrists, eighteen did not answer the question dealing with the percentage of psychopaths; two reported a zero percentage; thirty-five reported a larger percentage of their psychopaths to be free from psychosis, while thirty-three reported that most of their psychopaths were also psychotic; and seven reported the same percentage for those with psychosis as for those without psychosis.

The outstanding characteristic revealed by Table 7 is the extreme diversity of the percentages of psychopathy as reported by psychiatrists in mental hospitals. Out of ninety-five replies to the questionnaire, seventy-five answered this particular question. Percentages of psychopathy reported by these seventy-five range from zero percent

TABLE 7. INCIDENCE OF PSYCHOPATHY REPORTED BY PSYCHIATRISTS IN STATE MENTAL HOSPITALS

Number of Psychiatrists Reporting	Percentage of Psychopathy Reported
23*	0-0.9%
21	1.0-1.9%
11	2.0-2.9%
4	3.0-3.9%
4	4.0-4.9%
0	5.0-5.9%
2	6.0-6.9%
1	7.0-7.9%
1	8.0-8.9%
1	9.0-9.9%
1	10.0-10.9%
0	11.0-11.9%
1	12.0-12.9%
1	13.0-13.9%
0	14.0-14.9%
0	15.0-15.9%
1	16.0-16.9%
0	17.0-17.9%
0	18.0-18.9%
0	19.0-19.9%
1	20.0-20.9%
1	60%
1	100%
Total 75	

*Two of these reported zero percentages.

Two psychiatrists, in addition to those represented in this table, reported number of cases (but not percentages).

Eighteen of the ninety-five psychiatrists did not give any report on extent of psychopathy.

(two instances) to one hundred percent (one instance). Twenty-three report percentages in the range from 0%-0.9%. This figure, however, is almost surely misleading, inasmuch as several of the very small percentages may be in error by

two decimal points.[19]

The correction of such errors would probably increase the number of psychiatrists giving the percentage as being in the range from 1.0%-1.9%, making this category the one most frequently reported. Beyond this, however, there is considerable diversity of percentages reported.

Table 8 shows the incidence of psychopathy reported by psychiatrists in correctional institutions. While thirty of these psychiatrists replied to the questionnaire, twelve did not answer this particular question. As in the previous instance, the variation in reported percentages is considerable. The figure given most frequently (three times) is ten percent, while two percent, fifteen percent, and twenty percent are each reported twice.

Four of the eight psychologists in correctional institutions reported percentages of psychopathy in their institutions. These were: 7.3%, 3-4%, 5%, and 14.2%.

Eighteen of thirty-eight superintendents of juvenile correctional institutions reported upon the incidence of

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[19]For example, one psychiatrist reported a percentage of 0.009%, which would mean nine out of 100,000 cases. In another instance the number of cases and the total hospital population were given as well as the percentage of psychopaths; but here it was evident that the person calculating percentages had failed to take account of the percentage mark and had given the percentage as 0.144%. In this instance, however, since figures as well as percentages were supplied, the correction was made to 1.44%. In all other instances the figures are recorded just as they were given in the questionnaires.

psychopathy, and six others indicated that they could make no report on this question because of faulty or inadequate records. Of the eighteen, four reported a zero percentage, while six others reported less than five percent; three reported between five and nine percent; three others put the percentage at between ten and fourteen percent; and one gave twenty-five percent as the figure for his institution.

Out of sixteen superintendents of adult correctional institutions giving percentages of psychopathy, seven reported less than five percent (with three of these being zero percentages), three reported between five and nine percent, and two put the figure at ten percent. The following figures were given one time each: 19%, 20%, 27.6%, and 52%. Eleven others did not answer this question.

Only four out of thirty-three departments of welfare gave percentages. These were: 0%, 4.1%, 15-20%, and 24%. Others reported "Figures not available," "Not computed," "Unknown," and "Don't know."

Seven of the sixteen independent juvenile courts supply data on this question. Two of these report a zero percentage, with one adding that there have been no psychopaths "in the nine and one-half years this court has been in operation." Other percentages given (once each) are: 0.33%, 1%, 8%, and 25%. Another reports that two juveniles during the past four years have been diagnosed

TABLE 8. INCIDENCE OF PSYCHOPATHY REPORTED BY PSYCHIATRISTS IN CORRECTIONAL INSTITUTIONS*

Number of Psychiatrists Reporting	Percentage of Psychopathy Reported
1	0%
1	1%
2	2%
1	5%
1	6%
1	8%
3	10%
1	12%
2	15%
2	20%
1	25%
1	35%
1	40%
Total 18	

*Twelve of these thirty psychiatrists did not report on incidence.

as psychopathic.

Six of the sixteen combined juvenile courts give percentages. Ten percent was given twice, while each of the following was listed once: 0%, 2%, 2-3%, and 50%.

Ten of the forty-four circuit courts give data on this question. Four of these give the percentage as zero, and another says that he has had one case out of eight hundred eighty which would fall in this category. Two place the figure at five percent, while the others list 1%, 2%, and 15%.

From nineteen judges on the magistrate court level the following replies were received: Four reported zero percentages, with two of these saying, "I have nothing like

this in my office" and "We have nothing of this nature." One listed one case, and another said, "Not over 1%." The other figure reported was one percent.

Summary. This chapter has dealt with the incidence of the psychopathic offender as reported upon in the current literature and the questionnaire-survey. The most obvious characteristic of the data is the marked diversity of reported percentages in both these sources. However, before considering further this aspect of the matter, the data presented in this chapter will be considered from the point of view of their relevance to the hypothesis that among criminals and delinquents there are some whom authorities in the field designate by the term "psychopath" or by some other roughly equivalent term. We have seen that such authorities as those cited in the current literature and psychiatrists attached to state mental hospitals and correctional institutions report on the percentage of psychopaths found in various correctional institutions and mental hospitals. Psychopaths in correctional institutions have obviously been convicted of some offense against the law. Furthermore, at least some of the psychopaths in mental hospitals (especially state mental hospitals) have been sent there by the courts after some alleged violation of the law. If authorities report any given condition (e.g., psychopathy) in terms of percentages among the law-violating population, it must necessarily be said that

these authorities accept the fact of the existence of the condition. Thus it appears that the hypothesis relating to the presence of psychopaths among those adjudged delinquent or criminal is to be accepted. Furthermore, if a condition is considered to be sufficiently different from other conditions to be reported in terms of percentage of institutional population, it would follow that authorities in the field consider the psychopathic offender to be materially "different" from other kinds of offenders. Thus we see that prison psychiatrists consider him different from the non-mentally abnormal offenders and that psychiatrists in mental hospitals consider him different from others who are mentally abnormal.

In Chapter IV we saw that many "key" persons in agencies and institutions entrusted with the responsibility for crime control (e.g., many judges and superintendents of correctional institutions) lack a minimal conceptual acquaintance with psychopathy, and hence are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. The next hypothesis states (in part) that many others are aware of the need for this distinction but, considered as a whole, show considerable diversity in regard to diagnostic criteria. This hypothesis will be considered more fully in Chapters VII and VIII, but the present chapter also has some bearing on the topic of diagnostic criteria among those who are aware of the need

for distinguishing between the psychopathic offenders and other offenders. It is in this connection that we consider the marked variations of incidence of psychopathy as discussed in the present chapter.

It would normally be expected that the incidence of psychopathy would vary considerably among such heterogenous groups as patients in mental hospitals, inmates in correctional institutions, and prisoners before the bar at the various courts. What we have found, however, is not only differences in reported percentages among these various groups, but also marked variations in reported incidence of psychopathy within each of these groups. What can be the explanation for such marked variations in reported percentages among those who can be said to possess minimal conceptual acquaintance? There would appear to be no answer except that diagnostic criteria vary widely. Other evidences of divergent diagnostic criteria will be discussed in Chapters VII and VIII, but the material presented in this chapter at the very least suggests that diagnostic criteria vary widely.

CHAPTER VI

DIAGNOSTIC PROCEDURES AND FACILITIES

Diagnosis, broadly considered, may be divided into two parts: (1) diagnostic criteria proper and (2) diagnostic procedures and facilities. The first of these is essentially a matter of the symptomatology employed as a standard for determining the psychopathic syndrome, while the other concerns principally the conditions under which the actual diagnosis is, or is not, made. This latter topic is the one to be considered in the present chapter.

All the material for this chapter comes from the questionnaire-survey. The questions considered in this connection were those dealing with the person or agency having responsibility for detecting and diagnosing the psychopath after a case has been brought to the attention of authorities, the time at which diagnosis is made and the method of making the diagnosis, the psychiatric and psychological services available, and provision for re-examination in order to determine the accuracy of the first diagnosis. The questionnaire-survey data regarding these topics will now be considered.

Person or Agency having Responsibility for Detecting and Diagnosing the Psychopath after a Case Has Been Brought to the Attention of Authorities. The following question

was asked in the questionnaires going to state departments of welfare and to all courts: "After a case has been brought to the attention of authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?"[1] Table 9 summarizes the replies.

Perhaps the most significant feature revealed by this summary is the prominence of the court as the agency upon which rests the responsibility for seeing that a diagnosis is made. Even where the actual diagnosis is made by someone else (such as a psychiatrist), it was stated or implied in several instances that the court would call in a physician or refer the defendant to someone else <u>if</u> the court suspects the existence of psychopathy. This can only mean that if the judge or other official does not "suspect" the condition or if attorneys or special agencies do not request mental examination, the condition could be present without anyone attempting to diagnose it. Thus in the great majority of court cases, under present practice, psychopathy will go undiagnosed if the judge is not sufficiently well versed in the knowledge of this condition to order an examination.

Table 9 also calls attention to the fact that many of those replying to the questionnaire did not answer this particular question; in fact, for all categories except

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[1] Complete answers are given in Appendix E-3.

TABLE 9. RESPONSIBILITY FOR DETECTING AND DIAGNOSING THE PSYCHOPATH

Source of Answers	Person or Agency Having Responsibility for Detecting & Diagnosing	Number of Times Such Person or Agency was Mentioned*
Dept. of Welfare (13 out of 33 answered this question)	State or local depts. of welfare	6
	Probation or parole officials	3
	Clinics	3
	The court	2
	Bureau Juvenile Research	1
	None	1
Independent Juvenile Courts (12 out of 16 answered this question)	Psychiatrist (court, institutional, or private)	5
	The court	4
	Clinics	3
	Psychologist	1
	Coroner	1
	Probation officer	1
Combined Juvenile Courts (10 out of 16 answered this question)	The court	5
	Clinic	1
	Receiving home for children	1
	Probation department	1
	State hospital	1
Circuit Court Level (18 out of 44 answered this question)	The court	6
	County, district, or state attorney	4
	None	3
	State hospital	3
	Commission of physicians or "qualified experts"	3
	Attorney for defendant	2
	Sheriff	1
	Private person	1
	Agency having charge of person	1
	Institution to which person is sent	1
	Jury	1
Magistrate Court Level (4 out of 19 answered this question	The court	3
	Psychologist or neurol.	1
	County physician	1

*In several instances more than one person or agency was mentioned as having this responsibility.

juvenile courts, there were more who failed to answer this question than there were who answered it. In at least most of such instances, it may reasonably be assumed that specific responsibility for detecting and diagnosing the psychopath is lacking.

It will be recalled from Chapter IV that many of those who answered this question either are not aware of the psychopathic concept or confuse it with some other kind of mental abnormality. Nevertheless, the picture of the situation as presented in the summary table may be considered broadly correct for psychopathy if there were awareness of the condition, inasmuch as the same person or agency probably can be assumed to have responsibility in all cases of mental disorder.

Time at Which Diagnosis Is Made and Method of Making Diagnosis. The question asked of psychiatrists in state mental hospitals and correctional institutions and the administrative heads of correctional institutions was the following:

> "If a diagnosis of psychopath is made, is it made
> a. Prior to admission to your institution?
> What person or agency has responsibility for detecting and diagnosing the psychopath?
> b. After admission to your institution?
> How detected in your institution?"[2]

On the basis of answers to this question it appears that diagnosis prior to admission to these institutions is

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[2]Complete answers are given in Appendix E-5.

made in relatively few instances. This is true particularly in regard to state hospitals, of which only thirteen out of ninety-five report that any diagnosis is made prior to admission. Ten out of thirty-eight psychiatrists and psychologists in correctional institutions, and eleven out of thirty-eight administrative heads of juvenile institutions report diagnosis prior to admission. On the other hand, not a single administrative head of an adult correctional institution reported that any diagnosis was made prior to admission to his institution.

In regard to method of making diagnosis after admission, psychiatrists in hospitals and psychiatrists and psychologists in correctional institutions are in general agreement. Typical answers are: "mental examination," "history and examination," and "standard clinical methods." It is, of course, quite possible that a good many of these psychiatrists include the history as a part of the examination. However, it often happens that the history as such is not mentioned. If this does indeed indicate failure to consider the history in making a diagnosis, the probability of making an accurate diagnosis is greatly reduced.

Administrative heads of correctional institutions report a variety of methods in making the diagnosis. Some indicate that the diagnosis is made following examinations by the psychologist or psychiatrist. Some other methods

may be noted:

> "Only when the condition becomes quite evident -- then examination is given by calling in member of staff of state mental hospital."
>
> "Upon advice of others or behavior of inmates."
>
> "If we observe psychopathic tendencies, apply to office of commissioner of mental hygiene and a psychiatrist is sent to examine the inmate."
>
> "Through peculiar behavior followed by tests given by the psychologist."

In summarizing this section, it may be said that diagnoses, when and if made, generally take place after admission to the institution. The psychiatrists and psychologists present a fairly consistent picture of diagnosis by mental examination and (sometimes) history. Administrative heads of correctional institutions report a wide variety of methods of diagnosis, and a number of these methods indicate that the administrative head must take the initiative in requesting an examination if one is to be made.

In regard to the courts and state departments of welfare, the question was framed differently. In this case, information was sought as to whether a diagnosis of psychopathy was made (a) after the case is brought to attention of authorities, but prior to the hearing or trial, (b) during the hearing or trial, (c) after the hearing or trial, but prior to commitment or sentence, (d) after commitment or after beginning to serve sentence, or (e) at some other

time.[3] Table 10 summarizes the answers.

From this table it would appear that diagnosis of psychopathy is made most frequently in juvenile and circuit courts after the case is brought to the attention of authorities, but prior to the hearing or trial. Judges on the magistrate court level report diagnosis made during the trial as frequently as prior to the trial, and state departments of welfare report diagnosis made most frequently after commitment. Typical answers given under "At some other time" (column "e" in Table 10) are the following: "While on probation," "After probation has been tried," "Between court hearings," "When the case is brought to the attention of the court," "At any time between arrest and completion of sentence," and "At any time it appears that he is in need of a psychopath" [sic].

One important qualifying factor not altogether evident in Table 10 is that the majority of those answering this question checked more than one of the above stages in the proceedings as the time at which diagnosis is made; in fact, several checked all of the possible stages. This would seem to indicate that in at least many instances the diagnosis is as likely to be made at one stage in the proceedings as at another.

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[3] Answers are given in Appendix E-4.

TABLE 10. STAGES AT WHICH DIAGNOSIS IS MADE IN COURTS AND WELFARE AGENCY PROCEEDINGS

Source of Answers	Number of Times Diagnosis Reported Made*				
	a	b	c	d	e
State departments of welfare (13 out of 33 answered this question)	5	3	5	9	3
Independent juvenile courts (13 out of 16 answered this question)	9	4	6	3	6
Combined juvenile courts (10 out of 16 answered this question)	7	3	1	0	0
Circuit court level (16 out of 44 answered this question)	14	7	7	5	4
Magistrate court level (5 out of 19 answered this question)	4	4	2	2	2

*In many instances diagnosis was reported as being made at more than one stage in the proceedings.

a -- After case is brought to attention of authorities, but prior to the hearing or trial
b -- During the hearing or trial
c -- After hearing or trial, but prior to commitment or sentence
d -- After commitment or after beginning to serve sentence
e -- At some other time

Psychiatric and Psychological Services Available. The questionnaire asked whether a psychologist or psychiatrist was "available for use in your work." It was further requested that information be given as to whether such a psychiatrist or psychologist was (a) attached to court, institution, or department full-time, (b) attached part-time, or (c) a specialist called in, or a specialist to whom cases are sent.[4] Table 11 provides a summary of the answers.

This table shows that in seventy-nine correctional institutions[5] there are full-time psychiatrists in six, part-time psychiatrists in twelve, full-time psychologists in twenty-one, and part-time psychologists in ten. (A few of these have both psychiatrists and psychologists.) Thirty-two report psychiatric specialists who are called in or to whom cases are sent, while eleven report the availability of psychological specialists. At the same time, twelve of the seventy-nine institutions report that no psychiatric or psychological service is available, and eight others do not answer this question.

Six out of thirty-three departments of welfare report no psychiatric or psychological service available, and nine others give no information on this topic.

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[4]Complete answers are given in Appendix E-6.

[5]This figure includes fourteen institutions whose psychiatrists or psychologists answered the questionnaire sent to the superintendents.

TABLE 11. PSYCHIATRIC AND PSYCHOLOGICAL SERVICES AVAILABLE

Source of Answers	Psychiatric Services			Psychological Services			None	Number of These Not Answering This Question
	a	b	c	a	b	c		
6 psychiatrists in correctional institutions*	3	2	1	4	1	0	0	0
8 psychologists in correctional institutions*	1	2	3	7	1	0	0	0
38 superintendents juvenile correctional institutions	2	5	15	9	6	4	5	5
27 superintendents adult correctional institutions	0	3	13	1	2	7	7	3
33 departments of welfare	4	2	9	9	2	6	6	9
16 independent juvenile courts	2	4	9	3	2	6	1	1
16 combined juvenile courts	0	0	9	0	0	8	4	2
44 circuit courts	0	0	18	0	0	5	20	7
19 magistrate courts	0	0	5	0	0	2	9	5

*These answered the questionnaires sent to superintendents of correctional institutions.

a -- Attached full-time
b -- Attached part-time
c -- Specialist called in, or specialist to whom cases are sent

Sixteen independent juvenile courts report two full-time and four part-time psychiatrists and three full-time and two part-time psychologists. On the other hand, sixteen combined juvenile courts report no full-time or part-time psychiatrists or psychologists. Four say they have no psychiatric or psychological service of any kind available, and two others fail to answer the question. Forty-four circuit courts and nineteen magistrate courts likewise report no full-time or part-time psychiatric or psychological service available. Twenty on the circuit court level and nine on the magistrate court level (in addition to seven and five, respectively, not answering) report a complete lack of psychiatric or psychological services.

The report as to the number of specialists called in or specialists to whom cases are sent may give a false impression of the functioning of these agencies. In several instances those answering the questionnaires threw some additional light upon their answers, such as "The only work done along this line is by one of the psychiatrists from the state hospital" and "Can apply for help to office of commissioner of mental hygiene." It would be supposed that, theoretically at least, all agencies would have available this kind of help from such specialists. Those who report no such services available probably do not make use of even this limited amount of help.

Some qualifications need also to be made in regard to part-time psychiatric and psychological services. In at least some cases it has been indicated that such part-time help is given by a person who attempts to render such services to several institutions simultaneously. In one case it was reported, "Psychiatric consultant comes to this institution once in five weeks." Obviously there are very wide variations in what can be included in the reports of part-time services available.

Provision for Re-examination. The question asked was: "If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?" If the answer given was "Yes," the further question was: "At what intervals?"[6] Table 12 summarizes the results.

It will be noted that in nearly every instance provision for re-examination predominates by a wide margin. However, there are two qualifying factors. One of these is the number not answering this question. Where this question is not answered, reasonable doubt exists as to whether there is provision for re-examination.

The other qualifying factor is found in an examination of the stated intervals at which such re-examination is said to be made. In only relatively few instances

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[6]Complete answers are given in Appendix E-7.

TABLE 12. EXTENT OF PROVISION FOR RE-EXAMINATION FOR PSYCHOPATHY

Source of Answers	Provision Made By	No Provision Made By	Number of These Not Answering This Question
95 psychiatrists in state mental hospitals	80	8	7
30 psychiatrists in correctional institutions	21	1	8
8 psychologists in correctional institutions	5	2	1
38 superintendents of juvenile correctional institutions	21	4	13
27 superintendents of adult correctional institutions	15	6	6
32 departments of welfare	9	2	22
16 independent juvenile courts	12	0	4
16 combined juvenile courts	7	2	7
44 circuit courts	11	11	22
19 magistrate courts	3	3	13

does one find such replies as would indicate that the re-examination takes place at any regular intervals. More typical answers are: "frequent intervals," "as occasion demands," "no regular intervals," "same as other patients,"

"varies considerably," "when considered for release," "cases are always under observation," and "at any time."

When such qualifying factors are considered, it would appear that in a great many instances the machinery is geared for the perpetuation of any error in diagnosis.

Summary. This chapter has dealt with the conditions under which a diagnosis of psychopathy is, or is not, made. Some of the more significant findings may be summarized as follows:

In most courts psychopathy will go undiagnosed if the judge is not sufficiently well versed in the knowledge of this condition to order an examination.

A diagnosis of psychopathy (if made) is not usually made until after admission to a state mental hospital or correctional institution. The psychiatrists and psychologists present a fairly consistent picture of diagnosis by mental examination and (sometimes) history. If a diagnosis is made in a correctional institution, it appears evident in a great many instances that the administrative head of such an institution must take the initiative in requesting an examination.

The courts and welfare agencies indicate that diagnosis (if made) is likely to be made at any one of several possible stages in the proceedings.

Psychiatric and psychological services available for courts and correctional institutions are meager, with a

number reporting no services whatever available.

A reported predominance of provision for re-examination in order to check the accuracy of the first diagnosis is qualified by the few instances in which regular intervals or consistent procedure for re-examination were indicated.

CHAPTER VII

DIAGNOSTIC CRITERIA IN CURRENT LITERATURE

The wide variations in the reported incidence of psychopathy, as discussed in Chapter IV, strongly suggested divergent diagnostic criteria on the part of those who are aware of the need of distinguishing between psychopathic and non-psychopathic offenders. The present chapter will examine the symptomatology of psychopathy as it appears in current literature.

First of all we may note several direct statements regarding the confusion in diagnostic criteria. Levine writes of the progress made recently in the understanding of the neuroses and the psychoses. Then he adds, significantly: "In one diagnostic group, however, there has been a lag in the transformation. The understanding of the psychopathic personality has not kept pace with the understanding of the other groups."[1] Rabinowitz also calls attention to the current confusion: "It is . . . evident that attempts to limit or define this condition have been unsuccessful, as there is a lack of agreement as to the basic essential manifestations. The entire subject

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[1] Maurice Levine, "The Dynamic Conception of Psychopathic Personality," The Ohio State Medical Journal, vol. 36, no. 8 (Aug. 1940), p. 848.

appears to be arbitrary in the present state of our knowledge, and any particularized definition of a condition that is so vague would presuppose knowledge that we do not possess."[2]

In a similar vein, Van Vorst points out, "The diagnostic criteria for the clinical concept of 'psychopathic personality' have not been clearly established. Not only is there a lack of agreement concerning the symptoms characteristic of this condition, but also in regard to the actual psychological meaning of the term."[3] After an examination of the literature, H. F. Darling comes to the conclusion that "Definitions found in the literature are all incomplete and variable."[4] Furthermore, he has discovered no definition which he accepts as adequate. Karpman adds his word of dissatisfaction: "There is not even an unanimity as to the definition of the term psychopathy. To some psychiatrists the presence of a delinquency is

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[2]Arthur Rabinowitz, Jr., "Aspects of Psychopathic Personality," Medical Bulletin of the Veterans Administration, vol. 18, no. 2 (Oct. 1941), p. 181.

[3]Robert B. Van Vorst, "An Evaluation of the Institutional Adjustment of the Psychopathic Offender," American Journal of Orthopsychiatry, vol. 14 (July 1944), p. 419.

[4]Harry F. Darling, "Definition of Psychopathic Personality," Journal of Nervous and Mental Disease, vol. 101 (Feb. 1945), p. 121.

sufficient to label the reaction as psychopathic so that psychopathy becomes synonymous with the delinquency."[5]

Wilson and Pescor, in their Problems in Prison Psychiatry, state their opinion: "Practically every psychiatrist has his own idea of what constitutes a psychopathic personality; hence some consider all criminals as psychopaths, others reserve the term for criminals who become disciplinary or administrative problems while in prison, still others base their diagnosis on an unfavorable prognosis for rehabilitation which in turn is dependent upon personal bias, feelings, or hunches."[6]

Pargen's search of the literature in the field leaves him "amazed and baffled that a group so important has been ignored by some authorities, casually touched by others and its existence practically denied by still others. It is true that such a diagnosis may be unsatisfactory, and even unscientific, but we all know only too well that such a group does exist and does give an untold amount of trouble to every agency, social, legal, or medical, which

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[5]Ben Karpman, "On the Need of Separating Psychopathy into Two Distinct Clinical Types: The Symptomatic and the Idiopathic," Journal of Criminal Psychopathology, vol. 3 (July 1941), p. 112.

[6]J. G. Wilson and M. J. Pescor, Problems in Prison Psychiatry (Caldwell, Idaho: The Caston Printers, Ltd., 1939), p. 134.

contacts it."[7]

Symptomatological Categories. In order to make a comparative analysis of symptomatology given in the literature, it was necessary to devise categories which would make possible the inclusion of the various viewpoints presented. It is believed that the following thirty-three categories are adequate for this purpose:

1. Overt acts or traits which may occur as prominent features
2. Period in life when pattern of behavior becomes discernible
3. Duration of condition
4. Impressions generally made upon others
5. Attitudes in regard to self
6. Emotional aspects
7. Impulsive aspects
8. Volitional aspects
9. Semantic aspects
10. Judgment
11. Extent of self-control
12. Degree of trustworthiness
13. Response to kindness or special consideration
14. Response to discipline or other external attempts at control
15. Response to general life experience

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[7] T. H. Pargen, "The Constitutional Psychopath as a Community Problem," New Orleans Medical and Surgical Journal, vol. 91, no. 8 (Feb. 1939), p. 414.

16. Response to conflict or frustrating experiences
17. Adjustment to reality principle
18. Nature and extent of life-goal
19. Capacity for sustained activity in any one direction
20. Degree of dependability or reliability
21. Attitude toward and relationship with others
22. Acceptance of responsibility
23. Empathic capacity
24. Intellectual aspects
25. Sexual components
26. Alcoholic and drug components
27. Response to generally accepted values of his culture
28. Super-ego development and functioning
29. Somatic findings
30. Interpretation of difficulties
31. Insight
32. Important negative factors in differential diagnosis
33. General impression of total behavior

It will be noted that these categories are not mutually exclusive. While this may be undesirable in some respects, it is believed necessary if the investigator is to avoid weighting the words of the various authors with his own interpretations. The category "judgment" may be taken as a case in point. Let us say that an author refers to the psychopath as having "a defect of judgment."

This statement would, of course, be listed under "judgment." At the same time it is also true that particular defects of judgment would probably be reflected in a number of the remaining categories. But it would be entirely too gratuitous for the investigator to record such inferences which the author may or may not have had in mind. In some instances, of course, an author's comment is recorded under more than one heading -- e. g., some of the data in regard to sexual, alcoholic, and drug components are naturally given also under "overt acts."

Some of the categories shade, as it were, into others. "Response to discipline or other external attempts at control" and "response to general life experience" are examples, as are also "adjustment to reality principle" and "nature and extent of life-goal." The general rule has been that the emphasis of the individual authors is the guide used to determine the category in which any particular characteristic is placed.

More extended discussion of these categories will be given later in this chapter. At this time, however, a few additional preliminary considerations are in order.

The first category concerns "overt acts or traits which may occur as prominent features." The attempt is thus made to begin the consideration of categories with those conditions which are least likely to reflect the interpretations of the observer. The minimum of interpretation is involved in saying, for example, that a given

person has committed murder or robbery. Certain "traits" are also included in this category because many of the authors spoke, for example, of "criminal traits" rather than specific acts. Even so, the reporting of traits as stated, rather than attempting to translate them into overt acts, represents a minimum of interpretation approaching that of overt acts.

At the other extreme is the "general impression of total behavior" made upon the observer. This, of course, involves a maximum of interpretation. In between these two extremes no attempt is made to rank the categories in terms of the degree of interpretation demanded by the observer. Some can be determined with relative objectivity -- e. g., the psychopath's own "interpretation of difficulties." Others depend primarily upon inferences drawn by the observer; and of course inferences vary greatly.

It must also be pointed out that some of these categories may seem to deal with etiology as much as with symptomatology. The dividing line is exceedingly tenuous and finely drawn, and it is probably true that equally competent observers will not be in complete agreement as to what should be included in symptomatology and what in etiology. Since the authors being considered have oftentimes not made such a division, but have indeed often made a particular etiological concept an important feature in diagnosis, the difficulty confronting the investigator has been multiplied many times. Nevertheless, some decision

as to procedure has to be reached. The attempt has been made to place the more remote, though not necessarily ultimate, interpretative factors in etiology. To illustrate on a fairly simple plane: if someone defines a psychopath as one who commits anti-social acts, he may then explain these acts on the basis of faulty judgment or some defect in the emotional or volitional aspects of the personality. He may then go on to explain these defects in terms of, for example, constitution. In such an instance, I should place the anti-social acts and the defects in judgment, emotion, and volition in symptomatology, while "constitution" would be considered as belonging to etiology. If, to proceed further, an attempt should be made to explain constitution on an hereditary basis, heredity would also be included in etiology.

We may now proceed to a more direct examination of symptomatology as reported in the current literature.

It is to be hoped that Appendix D-1 will be examined carefully in connection with the following analytical statements in the body of the text. This portion of the appendix presents the authors chronologically in each of the thirty-three categories, and gives relevant quotations and summary statements in each instance.

The thirty-three categories dealing with symptomatology will now be analyzed.

1. Overt Acts or Traits which May Occur as Prominent Features. The data indicate that just about every kind of

socially undesirable act or trait is believed to be characteristic of the psychopath. Furthermore, although some authorities list a small number of such acts or traits, others are impressed with the variety and range of the activities. Not all acts of all psychopaths are to be considered criminal. It appears that no one act or no one kind of act is to be considered characteristic. This, however, can hardly exclude the possibility that individual psychopaths may specialize, as it were, in particular kinds of activities. This aspect of the matter will be discussed more thoroughly in Chapter XII.

2. Period in Life When Pattern of Behavior Becomes Discernible. In most forms of illness it is customary to speak of the "onset" of the condition. The use of this particular terminology is avoided in this instance because it might carry with it an implication that the condition begins at a specific time. Although the distinction may be a fine one, at least for the present purposes it seems more adequate to speak of the time when the pattern of behavior becomes discernible.

Most of the authors agree that the condition manifests itself very early in life, but just how early this manifestation occurs is not clear. It would appear that most of the authors find the condition discernible in the pre-pubertal stage. Darling, however, maintains that it

"develops before or during puberty . . . . "[8] Cleckley[9] does not believe that the condition necessarily appears at a very early age, and he cites the case of a young man who had reached late adolescence before the condition appeared. Pargen hedges by claiming that it "exists in all of them from the beginning" but "manifests itself at different times."[10]

3. Duration of Condition. This category should not be confused with that of prognosis, which will be considered in Chapter XI, although the relationship between duration and prognosis is obvious. The question might be phrased: Does this condition run a brief course or an extended one? Is it episodic or is it continuous? An implied question would be: Can diagnosis be made on a cross-sectional view of the personality, or must a longitudinal view be deemed essential?

The authors agree that the condition is continuous rather than episodic. (This, of course, would not rule out acute episodes in the continuum.) However, there is disagreement as to whether or not normal maturation proc-

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[8]Harry F. Darling, "Definition of Psychopathic Personality," Journal of Nervous and Mental Disease, vol. 101, no. 2 (Feb. 1945), p. 125.

[9]Cleckley, op. cit., pp. 254-255.

[10]Pargen, loc. cit.

esses exercise a benign effect. Mangun finds the "Symptomatology more marked when the subject is under thirty years of age,"[11] and Abrahamsen thinks that these offenders will "have a chance to mature and to adjust socially when they reach about forty-five."[12] On the other hand, Caldwell finds "more or less life-long traits,"[13] and Darling says the condition is "of lifelong duration in almost all cases."[14] However, all agree that the duration is for a number of years (as compared with days or months) at the very least.

4. Impressions Generally Made Upon Others. This category presents several apparent contradictions. Several of the authors cited point out that the psychopath makes a good first impression. Cleckley describes him as "usually a very attractive person superficially,"[15] and

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[11] Clarke W. Mangun, "The Psychopathic Criminal," Journal of Criminal Psychopathology, vol. 4, no. 1 (July 1942), p. 118.

[12] David Abrahamsen, Crime and the Human Mind (New York: Columbia University Press, 1944), p. 198.

[13] John M. Caldwell, Jr., "The Constitutional Psychopathic State (Psychopathic Personality). I. Studies of Soldiers in the U. S. Army," Journal of Criminal Psychopathology, vol. 3, no. 2 (Oct. 1941), p. 171.

[14] Darling, loc. cit.

[15] Cleckley, op. cit., p. 238.

Caldwell refers to "ingratiating and appealing behavior . . . ."[16] On the other hand, Henderson is impressed by the psychopath's insensibility and callousness,[17] and Karpman describes him as "willful, stubborn, obstinate . . . ."[18] Wooley finds him "almost invariably superficially pleasant and likeable."[19]

It is probable that many of these apparent contradictions would be resolved if we knew the conditions under which the psychopath was being observed. A personnel director interviewing him for a job might be so favorably impressed as to offer him a position immediately, while the "obstinate" aspect of his nature might be the first impression gained by a prison warden or someone else to whom the psychopath was being brought against his will.

5. Attitude in Regard to Self. Everyone agrees that the psychopath is, at the least, "selfish."[20] The extent

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[16]Caldwell, op. cit., p. 172.

[17]Henderson, op. cit., p. 65.

[18]Ben Karpman, "The Principles and Aims of Criminal Psychopathology," Journal of Criminal Psychopathology, vol. 1, no. 3 (Jan. 1940), p. 203.

[19]Lawrence F. Wooley, "A Dynamic Approach to Psychopathic Personality," Southern Medical Journal, vol. 35, no. 10 (Oct. 1942), p. 928.

[20]Edward W. Twitchell, "Psychopathic Personality: As a Household Problem," California and Western Medicine, vol. 48, no. 6 (June 1938), p. 423.

of his egocentricity is not clear. Presumably all would agree with Sprague that he is "more self-centered than the ordinary individual . . . ."[21] Karpman is more specific in his interpretation of "utter and complete selfishness . . . ."[22]

The extent and degree of egocentricity constitutes the only difference of opinion in this category, and the difference is made evident by lack of attention to detail rather than by any directly conflicting statements.

6. Emotional Aspects. All sources indicate some sort of emotional disturbance for the psychopath. Emotional instability and immaturity are the most frequently mentioned specific characteristics in this respect. Many other reported characteristics lack the specificity essential for differential diagnosis, such as Darling's statement of deviations in the "emotional components of the personality . . . ."[23] A statement like "rapid swings from elation to depression for trivial causes"[24] tells us a great deal more.

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[21]George S. Sprague, "The Psychopathology of Psychopathic Personalities," Bulletin of the New York Academy of Medicine, vol. 17 (Dec. 1941), p. 916.

[22]Karpman, "The Principles and Aims of Criminal Psychopathology," p. 203.

[23]Darling, loc. cit.

[24]Caldwell, op. cit., p. 172.

Some of the authors attempt a deeper analysis of the emotional life. Karpman finds that they "seem never faced with emotional conflicts,"[25] while Noyes and Haydon point out the "poverty of sentiment . . . ."[26] Cleckley refers to "general poverty of affect" and is impressed by "a readiness of expression rather than a strength of feeling."[27] Richards describes the emotional make-up as "shallow, casual, almost cold-blooded . . ."[28] Maughs notes "without any deep emotional ties."[29] Silverman finds the affect "cold, humorless and lacking in qualities of genuine warmth, gratitude and remorse."[30] At least some of these expressions would seem to be at variance with

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[25]Karpman, "The Principles and Aims of Criminal Psychopathology," p. 204.

[26]Arthur P. Noyes and Edith M. Haydon, A Textbook of Psychiatry (New York: The Macmillan Company, 1940), p. 213.

[27]Cleckley, op. cit., p. 245.

[28]Esther Loring Richards, Introduction to Psychobiology and Psychiatry (St. Louis: The C. V. Mosby Company, 1941), p. 146.

[29]Sydney Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," Journal of Criminal Psychopathology, vol. 3, no. 4 (April 1942), p. 697.

[30]Daniel Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," Archives of Neurology and Psychiatry, vol. 50, no. 1 (July 1943), p. 19.

the "Inconsistent worry" noted by Caldwell.[31]

Summarizing the emotional aspects, we find agreement as to the fact of emotional deviations, but the nature of those deviations is by no means agreed upon, except in regard to a kind of common denominator of immaturity and instability.

7. Impulsive Aspects. "Impulsive" is the adjective used or implied in every instance. Szurek is impressed by the "apparent urgency of their impulsive needs . . . ."[32] Cleckley finds violent acts, when they occur, "done on impulse and without previous planning."[33] In general, however, there is no attempt at a delineation of the impulsiveness.

8. Volitional Aspects. The analysis of this section will be considered in connection with the one dealing with the extent of self-control.

9. Semantic Aspects. This aspect of the problem has so impressed Cleckley that he makes a strong case for the adoption of semantic dementia as the proper designation of the condition. Thus he speaks of "mind or personality

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[31]Caldwell, op. cit., p. 172.

[32]Stanislaus A. Szurek, "Notes on the Genesis of Psychopathic Personality Trends," Psychiatry, vol. 5, no. 1 (Feb. 1942), p. 2

[33]Cleckley, op. cit., p. 210.

so damaged that experience as a whole cannot be grasped or utilized in its significance or meaning."[34]

Among those who attempt in any way to deal with the semantic aspect of the question, there is general agreement as to some defect in this respect.

10. Judgment. All authors dealing with the question of judgment report some defect. The extent of this defect is not dealt with except in a few instances. The Statistical Manual cites "marked defects of judgment;"[35] Cleckley finds "most execrable judgment;"[36] and Pargen notes "an absolute lack of judgment . . . ."[37] Such statements are, of course, much more specific than those which stress merely "defective judgment."[38]

11. Extent of Self-control. The key-note of this

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[34] Cleckley, op. cit., p. 268.

[35] Statistical Manual for the Use of Hospitals for Mental Diseases, Tenth Edition (Utica, New York: State Hospitals Press, 1942).

[36] Cleckley, op. cit., p. 240.

[37] Pargen, op. cit., p. 414.

[38] Clarke W. Mangun, "The Destiny of the Psychopathic Criminal," Proceedings American Prison Association (1939), p. 309, and J. D. Reichard, "The Psychopathic Personality: An Organic Viewpoint," Proceedings American Prison Association (1942), p. 144.

category is sounded in such expressions as "irresistible,"[39] "inability,"[40] and "incapable."[41] All the authors dealing directly with this question appear to agree not only that inhibitory control is lacking but that it is lacking to a degree which appears to be well-nigh absolute.

In contrast, however, are the findings under "volitional aspects." Hulbert indicates that some are "the wilful perverse . . . ."[42] If even some of the "perverse" will to be perverse, it is quite a different matter from saying that their behavior is incapable of being controlled.

12. Degree of Trustworthiness. It would be hard to reconcile the two expressed points of view under this heading. Wittels is convinced that they are "completely faithless,"[43] while Pargen indicates that they "prove trustworthy, under disciplinary supervision."[44]

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[39]Lowell S. Selling, Diagnostic Criminology (Ann Arbor, Michigan: Edwards Brothers, Inc., 1935), p. 138.

[40]Harold S. Hulbert, "Constitutional Psychopathic Inferiority in Relation to Delinquency," Journal of Criminal Law and Criminology, vol. 30, no. 1 (May-June 1939), p. 8.

[41]Mangun, "The Destiny of the Psychopathic Criminal," p. 308.

[42]Hulbert, op. cit., p. 12.

[43]Fritz Wittels, "Kleptomania and Other Psychopathic Crimes," Journal of Criminal Psychopathology, vol. 4, no. 2 (Oct. 1942), p. 212.

[44]Pargen, op. cit., p. 415.

13. Response to Kindness or Special Consideration. The two sources dealing with this topic are in agreement that the psychopath does not respond favorably to kindness or special consideration.

14. Response to Discipline or Other External Attempts at Control. This is one of the most important of the topics to be considered. Not only does it rate a major place in regard to diagnosis, but it has a significant bearing on prognosis and treatment possibilities.

From the point of view of the majority reporting on this topic, the evidence indicates a decided lack of favorable response to discipline or other external attempts at control. Mangun finds psychopaths "incorrigible,"[45] and Karpman discovers that they are "resistant to any attempt made to improve them."[46] Caldwell notes "a lack of amenability to correction, discipline, or reward,"[47] and Cleckley is sure that "no punishment will make the psychopath change his ways."[48] Hall describes them as "peculiar-

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[45] Mangun, "The Destiny of the Psychopathic Criminal," p. 208.

[46] Karpman, "The Principles and Aims of Criminal Psychopathology," p. 203.

[47] Caldwell, op. cit., p. 171.

[48] Cleckley, op. cit., p. 241.

ly unamenable to discipline."[49] Silverman[50] and Van Vorst[51] point out the very serious disciplinary problem which the psychopath presents in prison.

Concerning military life, which some seem to recommend for the psychopath, Hall says that "the Army is no place for such persons . . . ."[52] Strecker puts the matter rather strongly: " . . . in World War I the lesson was thoroughly learned that the constitutional psychopathic inferior cannot by any of the devices of psychiatry be made adequate for military service. It seems unfortunate that this lesson had to be expensively and sadly relearned in World War II."[53] Griswold expresses a similar point of view in regard to the Navy.[54]

On the other hand, Otis says, "During the World War

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[49]Roscoe W. Hall, "Peculiar Personalities: Disorders of Mood; Psychopathic Personality," War Medicine, vol. 1, no. 3 (May 1941), p. 385.

[50]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 21.

[51]Robert B. Van Vorst, "An Evaluation of the Institutional Adjustment of the Psychopathic Offender," American Journal of Orthopsychiatry, vol. 14 (July 1944), p. 493.

[52]Hall, op. cit., p. 386.

[53]Edward A. Strecker, "Military Psychiatry," One Hundred Years of American Psychiatry, p. 407.

[54]W. R. Griswold, "Constitutional Psychopathic State As Related to the Navy," United States Naval Bulletin, vol. 40, no. 3 (July 1942) pp. 646-651.

we had no trouble with psychopaths in the Army . . . ."[55] Pargen finds that the "vast majority make good patients or convicts" and that they "lend themselves to routine and prove trustworthy, under disciplinary supervision."[56]

Thus, in this category we see expressions of almost directly opposite points of view.

15. Response to General Life Experience. This category is a kind of extension of the last one considered. The distinction is that this deals with experience in general, whereas the other concerned the more specific experience of discipline or other direct attempts to control behavior.

Nearly all agree that psychopaths fail to learnor to profit by experience. Some indicate that this failure is in the nature of an inability. For example, Wilson and Pescor maintain, "Personal experience, no matter how bitter or beneficial it may be, teaches them nothing; neither can they draw any adequate conclusion from the experience of others."[57] The only contrary point of view is that presented by Wooley, who insists that they have learned from experience sufficiently to know that their

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[55] Walter J. Otis, discussion of Pargen, op. cit., p. 417.

[56] Pargen, op. cit., p. 415.

[57] Wilson and Pescor, op. cit., pp. 131-132.

family and friends protect and indulge them. He suggests the following modified formulation of this characteristic: "they continue to carry out behavior patterns which seem to profit them little and irritate their fellow men, even though such behavior has at times caused themselves injury."[58]

16. Response to Conflict or Frustrating Experience. This characteristic may be summarized by the statement of Karpman that they "can't stand privation well" and that they "easily blow up when the situation becomes a bit stressful."[59] Noyes and Haydon find that they are more prone than normal persons to develop psychoses, particularly those which are called the situation psychoses.[60] As Silverman puts it, "Tolerance to frustration or tedium is poor . . . ."[61]

All this is in contrast to the previously quoted emphasis of Pargen that the "vast majority make good patients or convicts" and that they "lend themselves to routine . . . ."[62]

17. Adjustment to Reality Principle. All the au-

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[58]Wooley, op. cit., p. 929.

[59]Karpman, op. cit., p. 206.

[60]Noyes and Haydon, op. cit., p. 216.

[61]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 19.

[62]Pargen, op. cit., p. 415.

thors who deal with this topic seem to be agreed that the psychopath lives in terms of the pleasure principle. For example, Maughs finds the characteristics of "pleasure at any cost"[63] and "Laziness except in the fruitless pursuit of pleasure."[64]

18. Nature and Extent of Life-goal. Obviously this topic is very closely related to the previous one, and inferences from either one of these categories can be made in regard to the other.

The authors dealing with this topic agree in general with the proposition that the psychopath is entirely without any kind of far goal in life or that he is unable to follow such a goal if he has one. Lindner, however, makes a slight exception in regard to a selfish goal which is "capable of immediate realization by a sharply accented spurt of activity . . . ."[65] On the whole, however, he finds them characteristically aimless.

19. Capacity for Sustained Activity in Any One Direction. Caldwell makes "frequent change"[66] the "most easily

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[63]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 512.

[64]Ibid., p. 713.

[65]Robert M. Lindner, Rebel Without a Cause (New York: Grune and Stratton, 1944), p. 3.

[66]Caldwell, op. cit., p. 171.

detected characteristic"[67] of a psychopath. Richards finds an "inability to stick to any one activity for more than few months at a time."[68] All may be said to agree that the psychopath's capacity for sustained activity in any one direction is exceedingly limited, and that this particular lack of capacity shows up in frequent changes of many sorts.

20. Degree of Dependability or Reliability. Among those who deal with this topic, agreement is evident that the psychopath is "not to be depended upon . . . ."[69]

21. Attitude Toward and Relationship With Others. It is agreed that the psychopath is conspicuous by his failure to get along with other people. This applies both in regard to close interpersonal relationships and relationships with a larger social group as well as with society as a whole. The more exact nature of this disturbance in relationship with others is a matter of varying interpretation. Pargen thinks that it is a matter of "total lack of consideration for others . . . ."[70] This

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[67] Ibid., p. 179.

[68] Richards, op. cit., p. 145.

[69] M. R. Kaufman, "The Problem of the Psychopath in the Army," Proceedings American Prison Association (1942), p. 129.

[70] Pargen, op. cit., p. 414.

of course, would merely be the obverse of the previously considered egocentricity of the psychopath. Karpman thinks that these people "do not and seemingly cannot develop those binding emotions and tender attachments which lie at the very basis of human evolution and our whole social structure."[71] Cleckley finds what he interprets as an absolute "incapacity for object-love . . . ."[72] Maughs stresses the parasitic element in his emphasis on "the ever recurring impulse to live at the expense of others without making any return . . . ."[73]

22. Acceptance of Responsibility. The failure to accept responsibility is a point on which the authors dealing with this topic are in agreement. As Karpman puts the matter, the psychopath possesses "no appreciation of the meaning of responsibility of any sort . . . ."[74]

23. Empathic Capacity. Only three of the authors under consideration appear to consider this characteristic, but among the three agreement is reached that the psychopath shows a deficiency in the capacity to feel for and with others.

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[71]Karpman, op. cit., p. 203.

[72]Cleckley, op. cit., p. 241.

[73]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 515.

[74]Karpman, op. cit., p. 204.

24. Intellectual Aspects. Extent of intelligence represents one of the areas of considerable disagreement. Several of the authors, of whom Twitchell is typical in this respect, include variations of intelligence from "low-normal to genius."[75] Others appear to indicate that the intelligence of the psychopath is mainly average or above. The point of dispute is chiefly as to whether or not a person with intelligence below average can be considered a psychopath. Darling[76] makes "without intellectual impairment" a delineating factor, as do apparently several others.

Some other aspects of intelligence are brought out in this analysis. Lindner refers to "the amazing excess-cargo of uncoordinated and useless information . . . ."[77] He finds such knowledge as is present to be superficial and undigested. Silverman calls attention to the fact that "Although sometimes there is an appearance of brilliance, thinking is superficial and at a plane far below that anticipated from the psychometric test level."[78] Richards refers to a kind of "dumbness" entirely apart

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[75] Twitchell, op. cit., p. 423.

[76] Darling, op. cit., p. 125.

[77] Lindner, op. cit., p. 6.

[78] Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths." p. 19.

from intelligence as measured by any formal psychometric examinations.[79] Cleckley calls attention to the fact that the intellectual powers are non-deteriorating.[80]

The main point of disagreement (a serious one when it is considered in the differential diagnosis with respect to feeblemindedness) concerns whether or not a person of below average intelligence should be diagnosed as a psychopath.

25. Sexual Components. Sexual deviations constitute the common denominator for the material presented in this category. As soon as we leave this one point of agreement, which really does not tell us very much, we find considerable diversity. Wholey,[81] Henderson,[82] Karpman,[83] Reichard,[84] and the Statistical Manual are some of the sources which emphasize particularly the sex perversions

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[79]Richards, op. cit., p. 145.

[80]Cleckley, op. cit., p. 238.

[81]Cornelius C. Wholey, "Psychiatric Report of Study of Psychopathic Inmates of a Penitentiary," Journal of Criminal Law and Criminology, vol. 38, no. 1 (May-June 1937), p. 58.

[82]Henderson, op. cit., pp. 75 ff.

[83]Karpman, op. cit., p. 204.

[84]Reichard, op. cit., p. 144.

as being characteristic. Several emphasize "a sex drive considerably above the average . . . ."[85]

In contrast to these points of view, Cleckley maintains that homosexuality and other perversions are not characteristic, although they sometimes occur.[86] Like others, he notes great promiscuity, but he finds that it is from "lack of self-imposed restraint" rather than because of a particularly strong sexual drive.[87]

Several of the authors emphasize the egocentric aspect of sexual relationships and a sort of general psychosexual immaturity. Maughs strikes a somewhat different note in pointing out "not only its utter lack of emotional tone but the mystery that surrounds it."[88] Along the same line, Wooley notes that "sexual activity is almost invariably diffuse and diverse . . . ."[89]

26. Alcoholic and Drug Components. The general opinion is that alcoholism or drug addiction is likely to be common among psychopaths. Wholey, however, in a study of 239 psychopaths in prison reports that he found more tee-

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[85]Karpman, op. cit., p. 204.

[86]Cleckley, op. cit., p. 252.

[87]Ibid., p. 253.

[88]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 714.

[89]Wooley, op. cit., p. 930.

totalers than among 200 non-psychopathic prisoners.[90] Cleckley calls attention to the "apparent lack of pleasure in drinking,"[91] and explains that the goal appears to be "a state of stupefaction or semi-stupefaction."[92]

27. Response to Generally Accepted Values of His Culture. Unanimity among the authors dealing with this topic is found to the extent that all agree that the psychopath frequently acts contrary to the generally accepted values of his culture. Szurek says he is "Unable . . . to acquire satisfactions in culturally acceptable ways."[93] Sprague offers this explanation: "Apparently the culture values are viewed from behind the psychopath's personal ramparts and are not taken into himself to become part of his own personality, there to cope with other traits in his own makeup."[94]

28. Super-ego Development and Functioning. Apparently all agree with Darling that there is "super-ego deficiency . . . ."[95] Karpman calls psychopaths "conscience-

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[90]Wholey, op. cit., p. 57.

[91]Cleckley, op. cit., p. 248.

[92]Ibid., p. 252.

[93]Szurek, op. cit., p. 2.

[94]Sprague, op. cit., p. 916.

[95]Darling, op. cit., p. 125.

less, unprincipled sense-of-guilt-less individuals."[96] Maughs asserts that "it seems fantastic that a psychopath could have a conscience . . . ."[97]

29. Somatic Findings. The somatic findings apparently do not bulk very large in the thought of most of the authors. Mangun mentions "Frequent history of neurotrophic disturbance -- enuresis, infantile asthma, and findings of subcynosis of the extremities . . . ."[98] Chornyak discovers "cortical atrophy" revealed by pneumoencephalographic studies.[99] Lindner finds arrhythmic functioning of the great bodily systems,[100] while both he and Silverman[101] refer to the difference in brain wave patterning as revealed by the electroencephalograph. Silverman, in fact, claims that "one essential factor in nearly all psychopathic personalities is a disturbed cortical function."[102]

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[96]Karpman, op. cit., p. 203.

[97]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 500.

[98]Mangun, "The Psychopathic Criminal," p. 118.

[99]John Chornyak, "Some Remarks on the Diagnosis of the Psychopathic Delinquent," American Journal of Psychiatry, vol. 97 (May 1941), p. 1332.

[100]Lindner, op. cit., p. 10.

[101]Daniel Silverman, "The Electroencephalograph and Therapy of Criminal Psychopaths," Journal of Criminal Psychopathology, vol. 5, no. 3 (Jan. 1944), p. 439.

[102]Ibid.

30. Interpretation of Difficulties. Universally, according to these authors, psychopaths find the reason for their difficulties somewhere outside themselves. As Silverman puts it, " . . . if the patient recognizes his difficulties at all, projection thinking is the commonest method of rationalizing them."[103]

31. Insight. The lack of insight is noted as an outstanding characteristic by authors touching on this topic with the exception of Menninger, who maintains that "some have very keen insight . . . ."[104] Cleckley finds some giving "an excellent mimicry of insight."[105]

32. Important Negative Factors in Differential Diagnosis. The most frequently mentioned negative factors have to do with absence of classical psychotic and psychoneurotic conditions. The presence of below-average I. Q. is accepted by others as being sufficient to place an individual in the feeble-minded group rather than among the psychopaths.

The absence of "inner emotional conflict" is pointed out by Wilson and Pescor.[106] Henderson maintains that

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[103]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 19.

[104]Karl A. Menninger, "Recognizing and Renaming 'Psychopathic Personalities,'" Bulletin of the Menninger Clinic, vol. 5, no. 5 (Sept. 1941), p. 152.

[105]Cleckley, op. cit., p. 246.

[106]Wilson and Pescor, op. cit., p. 130.

psychopaths are usually without shame and rarely show remorse.[107] Several others are similarly impressed.

Silverman finds that "Anxiety is rarely manifest, and then only in response to situational difficulty (e. g., incarceration) which the psychopath has brought on himself."[108]

The chief negative factor cited by Wooley is that psychopaths are "without evidence of organic damage to the central nervous system."[109]

Cleckley[110] and Maughs[111] point out the lack of real attempts at suicide. It will be noted that this is in contrast to the statements of certain other authors in regard to overt acts which the psychopath is likely to commit.

Bromberg and Thompson[112] make the failure of present methods of treatment a prominent factor in the differential diagnosis.

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[107]Henderson, op. cit., pp. 84,77.

[108]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 19.

[109]Wooley, op. cit., p. 926.

[110]Cleckley, op. cit., p. 252.

[111]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 511.

[112]Bromberg and Thompson, op. cit., pp. 70-89.

Obviously we are dealing here with rather wide divergencies of opinion.

33. General Impression of Total Behavior. Despite the considerable diversity found in regard to this topic, there does not necessarily appear to be any real contradiction. We are dealing simply with various aspects of the problem which have impressed the different authors in varying ways. Pargen describes the behavior of the psychopath as "completely unpredictable . . . ."[113] Wilson and Pescor are impressed by what they term "infantile reactions to adult situations . . . ."[114] Along a somewhat different line, both Cleckley[115] and Abrahamsen[116] find something suggesting a kind of unconscious will to fail.

Summary. This analysis of the symptomatology as it appears in current literature is marked by considerable diversity of opinion in several important respects. These are found particularly in regard to the period of life when the pattern of behavior becomes discernible, the extent of self-control, the response to discipline or other external attempts at control, the intellectual

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[113]Pargen, op. cit., p. 414.

[114]Wilson and Pescor, op. cit., p. 130.

[115]Cleckley, op. cit., p. 255.

[116]Abrahamsen, op. cit., p. 107.

aspects, insight, and the important negative factors in differential diagnosis. In addition, there are several other minor areas of disagreement which have been pointed out, particularly in regard to the extent and delineation of any given characteristic.

It is to be observed also that many of the authors cited do not deal with anything like the majority of the categories here considered. This is due in part to the fact that in some instances the literature deals only with specific topics rather than with total symptomatology. On the other hand, it is altogether evident that some of the authors are impressed only by certain of the characteristics discussed above. Their silence in regard to the features which impress others may be of considerable significance.

CHAPTER VIII

DIAGNOSTIC CRITERIA IN AGENCIES AND INSTITUTIONS

In the previous chapter we examined the symptomatology of psychopathy as it appears in the current literature. The present chapter considers the data on this topic made available through the questionnaire-survey.

Some hint of the symptomatological confusion among the personnel in agencies and institutions covered by the questionnaire-survey may be gained from the following excerpts from letters received in the course of this investigation. The superintendent of a state mental hospital wrote a lengthy letter indicating his concern about the problem of the psychopath, concluding with the words: " . . . we wish to state that we at this hospital feel that in spite of the volumes that have been written on this subject, we really know very little about the psychopath." The director of a state department of welfare expressed an oft-reported complaint: "We use the term 'psychopath,' but I believe we use it as you write it, in quotation marks. Sometimes it is a medical diagnosis and sometimes a social worker's identification of a familiar behavior pattern, but even in the former case it does not appear to have the same kind of significance as many medical diagnoses."

The question which called forth the data dealt with in this chapter was: "What definition or description of the psychopath serves as a guide for diagnosis in your work?" As has been explained earlier, it was thought that this kind of general question would be most adequate for eliciting a spontaneous representation of the working concepts employed in making a diagnosis of the condition.

The answers to this question are recorded verbatim in Appendix E-8. Although these definitions or descriptions take up too much space to be given in the main body of the text, a reading of them is strongly recommended as preliminary to the analysis which will be presented later in this chapter. Such a reading of the definitions reveals a diversity at least as great as has been observed in the symptomatology given in current literature.

In the definitions several references are made to the Statistical Manual published by the National Committee for Mental Hygiene and prepared in collaboration with the American Psychiatric Association. It will be recalled that this also was one of the sources considered under current literature. Among the psychiatrists attached to state mental hospitals, thirteen either quote this definition without direct reference to the source or simply state that they use the definition given in this source. Among psychiatrists attached to correctional institutions, one states that he uses the definition, and one of the

superintendents of adult correctional institutions also refers to it. Simply stating that the definition given in the Statistical Manual or the nomenclature of the National Committee of Mental Hygiene or American Psychiatric Association is followed may be on a different plane from actually writing out the definition. Writing it out without reference to the source may possibly indicate a more complete acquaintance with it. However, for this analysis each person who stated that he used such a definition is treated as though he had actually written it out.

Some definitions deserve special attention. One of the psychiatrists in state mental hospitals simply said, "Social misfit. His complete life history is considered." Another made this notation in the space for definition: "Accepted classical description." Another did not attempt a definition, but said, "These, of course, are diagnosed by close study and mental observation of personality, mannerisms, ideas and habits." And still another wrote down this statement: "Those which apply with closest approximation, and which are most useful; including the formulations of Adolph Meyer, Eugene Kahn, the Freudian school, and the nomenclatives of the National Committee of Mental Hygiene, of the Army, of the Navy, etc." Another made the following notation: "We probably follow Cleckley more closely than anyone else, but the meaning, limits, and applicability of the term vary some with each clini-

cian." Still another indicated that the definitions used were "those outlined in current recent texts in psychiatry."

One of the psychologists in correctional institutions defines a psychopath as "a person slightly or considerably unstable, yet not psychotic or actually criminally insane." Another simply writes the following characteristics: "criminality, perversion, emotional conflict, neuroses."

One of the psychiatrists in correctional institutions stated, "Anyone showing psychotic or psychoneurotic tendencies or potentialities to a degree that institutional care has been sought. This is not a definition but does cover our needs at this school 1900 inmates." Another simply wrote down the word "None." Still another wrote in the space provided for definition: "The term is a misnomer and means nothing. The patient has symptoms for only one reason and that is for you to make a diagnosis."

Several of the superintendents or correctional institutions indicated a probable lack of knowledge of the concept by making the following statements: "All mental cases are transferred to _____ State Hospital for treatment." "We do not have the psychopathic . . . . we have only delinquents or incorrigibles . . . ." The superintendent of a state school for girls wrote that she was not "in a position to fill out the enclosed questionnaire for the reason that we do not have cases of this kind in the School. In the event a juvenile is brought here who is a psychopathic case, she is generally sent to

one of our state hospitals for observation and X-rays. The doctors there make the diagnosis in the case and if the girl is mentally ill, she is kept in a psychopathic hospital. If her mentality and I. Q. are low, she is sent to one of the custodial schools." One questionnaire was answered by the chief clerk at a boys' industrial institute. He explained, "We do not handle psychopathic cases here at this particular institution. No boys under this category are sentenced here . . . ." He suggested that I would find some at the state hospital. The superintendent of a boys' training school wrote as follows: "If the observation of the members of the staff of this institution of a boy [sic] leads them to believe that he may be psychotic, the boy is referred to the staff physician, and if in his opinion there is the possibility of the boy being psychotic he recommends to the Board of Control of the State Institution that the boy be transferred to a State Hospital for observation and treatment. From that point on we are governed by recommendations of the psychiatrist of the State Hospital."

One superintendent gave the following: "Our own 'home-made' definition might be 'a psychopath is an individual whose emotions and mentalities are not normally perceptive and reactive.'" Some of the definitions which fail to define or which indicate a patent confusion of psychopathy with some other category are the following: "When a person's reactions are markedly different from his normal

reaction to his surroundings." "General lack of mental stability." "No arbitrary definition of a psychopath. Diagnosis is based on behavior in Prison." "A person who exhibits signs of suffering from a mental disease." "Failure to adapt, brooding habits, extreme nervousness, unusual irritability, etc." "An emotionally unstable personality, characterized by traits of mental disease." "Various moods of extreme mental and emotional display."

Some of the definitions given by the courts were as follows: "Chronic truancy, anti-social behavior, temper tantrums, etc." "Abnormal nervous and mental reaction and inability to adjust himself to normal human relations." "One characterized by extreme susceptibility to fears, doubts and has hallucinatory ideas that are becoming fixations." "A person other than drunkard, epileptic, feeble-minded, who is in need of treatment for his own good or the good of society." "Mentally ill." "One who can't keep out of trouble -- et cetera." "I have none. Each case on its own merits." "Haven't used any thus far." "Mental and nervous disorder which produces social instability." "Lunacy." "One who suffers from hallucinations, abnormal fears, or perhaps a very severe inferiority complex is, I think, a psychopath." "Any person who is mentally defective." "Statutory definition of insanity."

One wonders what kind of possible analysis can be made from such heterogeneous data. The definitions them-

selves tell the story most completely, but beyond that is there no basis for comparison?

One method of analysis would be to compare these definitions to the ideal definition, but from the material presented in the preceding chapter it appears that agreement has not been reached as to the specific characteristics of the ideal definition. Even some of those who report that they use the definition as given in the Statistical Manual referred to above state that they find it "wholly inadequate" and "not very explicit."

Another method would be to pursue the same technique followed in the previous section on the analysis of current literature. However, a reading of the definitions as given indicates quite clearly that marked diversity to an extent at least as great as that found in literature is altogether evident. It could hardly serve any useful purpose merely to belabor the obvious.

Furthermore, as great as the diversity appears, such diversity as might be measured within any one stated characteristic of the condition may not be the most significant consideration. If we may proceed on the assumption that one of the most essential factors in an adequate diagnosis of the psychopath is a coverage of all factors which may bear significantly on the diagnosis, then it may be possible that the extremely varying diagnoses are due not alone to disagreement within specific characteristics

but may perhaps be due even more directly to an inadequate number of characteristics being considered as essential to the syndrome. That is to say, if an accurate diagnosis is to be made, such a diagnosis should have not only depth (in regard to any one specific characteristic) but it should also have breadth (in regard to the number of characteristics which must be considered). It may be recalled at this point that thirty-three categories were considered in the section dealing with the analysis of the current literature. It was pointed out also that many of the authors appeared to leave untouched a number of these categories. This was partially explained by the fact that some authors made it their purpose to deal only with particular aspects of the question. In the present case, however, the situation is quite different. Those who answered the questionnaire were asked to give the definition or description which serves as a basis for their diagnosis. Therefore, we may assume that they have presented us with a rather complete coverage of their diagnostic criteria.

It seems reasonable, therefore, to explore these definitions on the basis of the symptomatological categories with which they deal, and to employ for this purpose the categories stated in the previous chapter.

Accordingly, each definition has been examined with a view to determining the symptomatological categories with which it deals. Whether any given definition deals much

or little with these categories or whether these definitions agree within themselves or with other definitions are matters not considered in this connection. It may be added that the scoring of the definitions on this basis has been extremely liberal, the attempt being made to include every category which was in any way touched upon by the person giving the definition. Of course, it is realized that any scoring by such a method is open to question, particularly in regard to some of the details. However, it is believed that anyone else who will likewise score these definitions on this basis will obtain substantially the same results even though there may be minor variations here and there.

Tables 13 and 14 present the results of this analysis for all psychiatrists, for psychologists attached to correctional institutions, and for superintendents of correctional institutions. Since it has already been shown in Chapter IV that minimal conceptual awareness is generally lacking among most of the others answering the questionnaire, it would seem unnecessary to analyze their answers in this way.

Table 13 shows the number of symptomatological categories employed in the definition and the number of persons employing such categories. For example, if only one definition included a consideration of only one of the thirty-three categories, and if this one-category definition was

given by only one person, the figure "1" would appear at the top of each of the two columns under the heading of the group in which the person giving the definition belongs.

TABLE 13. NUMBER OF SYMPTOMATOLOGICAL CATEGORIES EMPLOYED IN DEFINITIONS AND NUMBER OF PERSONS EMPLOYING THESE CATEGORIES

Number of Categories	Number of Persons Employing These Categories				
	State Mental Hospitals	Correctional Institutions			
	Psychiatrists	Psychiatrists	Psychologists	Supts. Juvenile	Supts. Adult
1	1	1	1	1	1
2	4	2	1	1	0
3	11	4	1	3	0
4	9	0	1	2	1
5	10	2	0	1	2
6	1	3	1	0	0
7	8	1	0	0	0
8	1	0	0	1	0
9	1	0	0	0	0
10	13	1	1	0	1
11	1	0	0	0	0
12	12	0	0	0	0
13	0	1	0	0	0
Totals	72	15	6	9	5
Others Not Answering This Question	23	15	2	29	22

This table calls attention to the following significant facts: Seventy-two of the ninety-five psychiatrists in state mental hospitals answered this question. The greatest number of categories employed in the definition was twelve, and this number was employed by twelve of these psychiatrists. The number of categories employed most frequently was ten (by thirteen psychiatrists). Eleven of these psychiatrists employed three categories, and ten of them made use of five categories in their definitions.

Fifteen of thirty psychiatrists in correctional institutions gave definitions. The maximum number of categories was thirteen (employed by one psychiatrist). The number of categories employed more frequently than any others was three, being used by four persons. Three psychiatrists made use of six categories, and two of those answering employed two categories in their definitions.

Six of the eight psychologists in correctional institutions answered this question. The greatest number of categories (ten) was employed by one person, while the next greatest number (six) was also employed by one person.

Nine of thirty-eight superintendents of juvenile correctional institutions gave definitions, and one of these employed eight categories. The number of categories employed most frequently (by three persons) was three,

while two persons made use of four categories.

Of the twenty-seven superintendents of adult correctional institutions, five answered this question. One of these employed ten categories. The greatest number of categories (five) was employed by two persons.

It will be recalled that ten categories were dealt with in the Statistical Manual. If this be accepted as the minimum number for any definition which is at all adequate, it is revealed that the great majority of persons used less than this number. What this table clearly shows is that a great number of those having to do with the diagnosis of the psychopathic offender employ a very limited number of categories. Even if it be granted that what they may say in regard to any one category is quite correct, it is still evident that a severe deficiency exists in regard to breadth of definition, or number of categories employed. As has already been suggested, this may help to account for the fact that the different diagnosticians vary so widely as to who should and who should not be described as a psychopathic offender.

Table 14 shows the individual symptomatological categories ranked according to the number of times they are employed in the definitions.

Examination of this table reveals that some categories were not used at all. Psychiatrists in state mental hospitals did not use categories number thirteen and

TABLE 14. SYMPTOMATOLOGICAL CATEGORIES RANKED ACCORDING TO NUMBER OF TIMES USED IN DEFINITIONS

State Mental Hospitals		Correctional Institutions							
Psychiatrists		Psychiatrists		Psychologists		Supts. Juvenile		Supts. Adult	
Category	Times Used	Category	Times Used	Category	Times Used	Category	Times Used	Category	Times Used
6	42	6	9	1	4	21	5	1	5
1	41	28	7	6	2	6	5	6	4
15	30	15	6	11	2	11	5	25	3
21	35	1	5	21	2	1	3	32	3
29	27	10	5	25	2	5	3	21	2
24	26	21	5	28	2	19	2	24	2
32	25	3	4	32	2	28	2	3	1
8	24	7	4	3	1	10	2	7	1
25	23	2	3	5	1	3	1	8	1
7	19	5	3	7	1	15	1	11	1
10	11	32	3	10	1	23	1	15	1
5	10	8	2	13	1	27	1	22	1
11	8	9	2	14	1	32	1	26	1
3	7	17	2	18	1	33	1	28	1
2	6	18	2	19	1	2	0	29	1
14	6	19	2	24	1	4	0	2	0
27	5	25	2	31	1	7	0	4	0
9	4	31	2	2	0	8	0	5	0
16	4	33	2	4	0	9	0	9	0
19	4	14	1	8	0	12	0	10	0
17	3	22	1	9	0	13	0	12	0
22	3	23	1	12	0	14	0	13	0
26	3	24	1	15	0	16	0	14	0
30	3	26	1	16	0	17	0	16	0
12	2	4	0	17	0	18	0	17	0
18	2	11	0	20	0	20	0	18	0
29	2	12	0	22	0	22	0	19	0
33	2	13	0	23	0	24	0	20	0
4	1	16	0	26	0	25	0	23	0
20	1	20	0	27	0	26	0	27	0
31	1	27	0	29	0	29	0	30	0
13	0	29	0	30	0	30	0	31	0
23	0	30	0	33	0	31	0	33	0

twenty-three. The psychiatrists in correctional institutions made no mention of categories 4, 11, 12, 13, 16, 20, 27, 29, 30. Psychologists in correctional institutions left untouched sixteen of the thirty-three categories,

while the superintendents of juvenile and adult correctional institutions failed to include nineteen and eighteen of these categories, respectively.

The category most frequently used by psychiatrists in state hospitals and correctional institutions was number six (the one dealing with emotional aspects), while for the others this category was used the second number of times. Beyond that, there seems to be little agreement as to which symptoms are most important in making a diagnosis of psychopathy.

These two tables show quite clearly the diversity of the diagnostic concepts used by those who deal with the psychopathic offender. Table 13 shows the relatively small number of categories employed in diagnosis, and Table 14 shows decided lack of agreement as to the specific categories which are included.

Summary. This chapter and the one preceding it have dealt with the diagnostic criteria employed by those who are aware of the need of distinguishing between the psychopathic and the non-psychopathic offender. Chapter VII concerned symptomatology in current literature only, while the present chapter has dealt with the results from the questionnaire-survey.

The method of analysis employed for the current literature was to devise symptomatological categories covering the psychopathic syndrome as it was described by

the various authors. Points of agreement and disagreement within each of thirty-three categories were then summarized.

These same symptomatological categories were employed also in the analysis of definitions or descriptions which psychiatrists in state mental hospitals and psychiatrists, psychologists, and superintendents of correctional institutions stated they used as guides for diagnosis in their work. In this case the categories were examined not for internal consistency but for the number employed in each definition and for the specific categories which were used most frequently.

The material presented in these two chapters indicates something of the extent to which many of the persons who possess minimal conceptual acquaintance with psychopathy are nevertheless employing divergent diagnostic criteria.

CHAPTER IX

ETIOLOGICAL FORMULATIONS

Etiology is important from the standpoint of the present study because of its bearing upon the question of therapy. Except in those instances where the emphasis is upon empirical therapy, etiological formulations are of primary importance. False assumptions about causative factors may exercise as deliterious an effect upon the outcome of treatment as correct etiological formulations may prove helpful. In any event, etiological confusion will almost surely be reflected in equally confused attempts at treatment. This chapter will therefore examine the etiological formulations as they are given in current literature and in the questionnaire-survey.

The following question was put to all psychiatrists to whom the questionnaire was sent: "What is your opinion as to the etiology of the psychopath?" The following possibilities were then listed for checking: "unknown, congenital, inheritance, physical disease (please specify what kind), some kind of psychic trauma in childhood, other etiological factors (please specify)."[1]

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[1] Complete answers to this question are to be found in Appendix E-12.

One hundred six psychiatrists answered this question. A number of these listed more than one etiological factor. The factor mentioned most often was "inheritance" (forty times), while "unknown" was checked by thirty-nine psychiatrists. However, fifteen of these thirty-nine gave one or more other factors in addition to "unknown," so that only twenty-four can be said to describe the etiology of psychopathy as altogether unknown. The next most frequently mentioned factor was "some kind of psychic trauma in childhood" (thirty-six times), and this was followed by "congenital" (twenty-five times) and "physical disease" (twelve times). Only six of those listing physical disease specified what kind: encephalitis was given four times, while "organic brain disease" and "any affecting nervous system" were each reported once.

Twenty-nine of these psychiatrists noted "other etiological factors," several of them listing more than one other factor. The most frequently mentioned factor of this sort pertained to faulty care or training (including expressions of faulty parental attitudes or relationships), which was given fifteen times. Some kind of environmental fault was mentioned ten times. Next in order came references to "constitution" (five times), broken or disorganized homes (three times), and head trauma at birth or injury at an early age (two times).

It seems evident, therefore, that considerable etiological diversity exists among the psychiatrists

covered in the questionnaire-survey.

The etiological formulations in current literature show much the same sort of diversity as those appearing in the questionnaire-survey. We may note, first of all, hereditary and constitutional factors. Selling speaks of psychopaths as "inherently defective."[2] Twitchell says that most of them are "hereditarily tainted . . . ."[3] Hulbert speaks of the condition in terms of "born with and not acquired,"[4] while Mangun calls it "basically a biologic problem . . . ."[5] Maughs finds that "the pattern of psychopathy is the same in all and bears no relation to intelligence or social background and environment. These latter may influence the course of the psychopathic individual, but they never change inherent personality. They may help disguise his broken life and make his going somewhat easier, but they are in no sense causative factors."[6] The Statistical Manual describes the condi-

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[2]Selling, op. cit., p. 153.

[3]Twitchell, op. cit., p. 423.

[4]Hulbert, op. cit., p. 3.

[5]Mangun, "The Destiny of the Psychopathic Criminal," p. 310.

[6]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 516.

tion as "apparently on the basis of constitutional defect . . . ."[7]

Some of the authors are frankly puzzled about the etiology of the psychopath. Cleckley, for example, terms psychopathy "a more inscrutable and complicated disorder than even schizophrenia."[8] On the other hand, Szurek finds "no greater mystery than other syndromes in psychopathology."[9] He expresses himself as convinced that one or both parents have "been seen unconsciously to encourage the amoral or anti-social behavior of the child."[10] Wooley also blames the condition on faulty training of the child.[11]

Certain physical illnesses or head injuries also are listed as etiological factors. Campioni has presented a report of three cases of cranial trauma in young people following which (at varying intervals) there developed behavior which impressed him as being similar to that known as the post-encephalitic personality, which in turn presents many features common to the psychopathic personality.[12]

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[7] Statistical Manual, loc. cit.

[8] Cleckley, op. cit., p. 280.

[9] Szurek, op. cit., p. 5.

[10] Ibid.

[11] Wooley, op. cit., p. 928.

[12] T. Campioni, "Cranial Trauma as an Etiological Factor in Personality Disorders of Children," Journal of Criminal Psychopathology, vol. 3, no. 3 (Jan. 1942), pp. 363-382.

Among the physical illnesses listed as etiological factors, encephalitis appears to be most important. The disease here referred to is generally called epidemic encephalitis in America and encephalitis lethargica in England; "sleeping sickness" and "sleepy sickness" are the terms employed by the man in the street. Pearce describes this illness as "an inflammatory disease of the brain tissues, and it may cause structural damage so grave and irreversible as to alter profoundly the temperament and personality of the child; e. g., a formerly good child becomes apache. Obvious cases of this disease display characteristic bodily signs, but many cases are much less distinctive and elude detection."[13] Craig points out that "in the older cases there appears to be little disorganization of behaviour but, on the contrary, the sequelae of the disease show essentially neurological features. In the adolescent or young post-encephalitic, neurological signs and symptoms are the exception rather than the rule where there is gross disorganization of behavior."[14]

The etiological factor which has been advanced with

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[13]J. D. W. Pearce, "Physical and Mental Features of the Juvenile Delinquent," in R. N. Craig et al, Mental Abnormality and Crime (London: Macmillan and Company, 1944), pp. 209-210.

[14]R. N. Craig, "Report on the Work of the Exeter Child Guidance Clinic," in R. N. Craig et al, op. cit., p. 303.

greatest prominence during the very recent past is disturbed cortical activity as indicated by the tracings of the electroencephalogram. Silverman is the outstanding proponent of this point of view. In 1943 he reported on a study of seventy-five criminal psychopaths of whom "only 15, or 20 per cent, had tracings classifiable as normal."[15] So important is this aspect of the matter that it may be well to consider also certain other reports of investigations into disturbed cortical activity.

In 1942 Brown and Solomon reported on an electroencephalographic study of twenty boys committed to a state training school for delinquents. The electroencephalographic records for seventeen of these twenty are described as abnormal in their representations of cortical electroactivity. Of the three boys who showed normal electroencephalograms, two are described as "accidental" delinquents. Of further interest is the fact that some favorable results followed dilantin medication (which is often used for epilepsy), thus suggesting a possible relationship between the etiology of psychopathy and epilepsy.[16]

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[15]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 25. See also Silverman, "The Electroencephalograph and Therapy of Criminal Psychopaths," Journal of Criminal Psychopathology, vol. 5, no. 3 (Jan. 1944), p. 439-466.

[16]Warren T. Brown and Charles I. Solomon, "Delinquency and the Electroencephalograph," American Journal of Psychiatry, Jan. 1942, pp. 499-503.

In the same year Brill, Seidemann, Montague, and Balser reported on the electroencephalographic examinations made of twenty-eight children brought before the Domestic Relations Court in New York City. "In 61 per cent of the entire group, the brain potentials suggested an underlying disorder in brain function. When only those with behavior disorders were considered, 74 per cent showed abnormal activity."[17] However, it should be noted that these authors add: " . . . we were unable to make any correlation between the type of behavior and the electroencephalographic abnormalities."[18]

In 1943 Knott and Gottlieb reported on an electroencephalographic study of forty-four patients diagnosed as psychopathic personality. Of these twenty-one (48%) were found to have normal electroencephalograms, while nine (20%) were abnormal and fourteen (32%) were questionable. "Thus, 52 per cent were outside the criteria of the normal range of variation."[19] The authors further point out: "As evaluated by the same criteria, only 6-10 per cent of a normal population have 'not normal' rhythms.

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[17]Norman C. Brill, Herta Seidemann, Helen Montague, and Ben H. Balser, "Electroencephalographic Studies in Delinquent Behavior Problem Children," American Journal of Psychiatry, vol. 98 (Jan. 1942), p. 497.

[18]Ibid.

[19]John R. Knott and Jacques S. Gottlieb, "The Electroencephalogram in Psychopathic Personality," Psychosomatic Medicine, vol. 5, no. 2 (April 1943), p. 141.

One might further add that normal EEG's are sometimes obtained in spite of known cortical pathology."[20]

In 1944 Solomon, Brown, and Deutscher reported on a comparative study of electroencephalographic findings for two paired groups for which the social, economic, and cultural background were said to be similar. The first group was composed of the twenty best-behaved boys in a junior high school class of one hundred thirty-one boys. Compared with these were the twenty boys considered most troublesome in this same class, nine of whom were regarded as psychopathic. The other group was composed of the ten best-behaved and least delinquent in an institution for delinquents. Contrasted with them were the ten most chronic delinquents in the same institution who manifested the most severe and chronic types of behaviour disorder. All ten were regarded as severely psychopathic.

In the first group (boys from a junior high school) there were twelve abnormal tracings for the twenty best-behaved, and eleven abnormal tracings among the twenty considered most troublesome. Among the training school group, abnormal tracings showed up for four of the ten best-behaved boys and nine of the ten who were most delinquent.

The authors, however, inject the following warning into their discussion: " . . . the results do not justify

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[20]Ibid.

use of the tracing as a measure for prognosis and treatment other than to regard the electrical cortical activity shown in an abnormal tracing as a probable or possible additional adverse factor . . . . It is certainly doubtful whether the measure we are at present using can be reliably correlated with the ill-defined and varied phenomena of behavior exhibited by the subjects under consideration in these studies. It would seem that the difficulty lies in attempting to correlate one partially known and poorly defined phenomenon (behaviour) in terms of another partially known phenomenon (electrical activity of the cerebral cortex). Behaviour is a reflection of the total personality, not totally represented in cortical electrical activity at all times or perhaps at any time . . . .

"It is not surprising that our present endeavors to measure the confused totality of behaviour as manifested in behaviour problem children in terms of cortical electrical activity have yielded results too complicated for clear interpretation."[21] These authors also call attention to "Gibbs' finding of many abnormal EEG's in college students of superior standing . . . ."[22]

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[21]Charles I. Solomon, Warren T. Brown, and Max Deutscher, "Electroencephalography in Behaviour Problem Children," American Journal of Psychiatry, vol. 101 (July 1944), p. 60.

[22]Ibid., p. 56.

It appears, therefore, that the various investigators are not fully agreed as to the interpretation of the electroencephalographic findings. It may very well be that improvements in apparatus and refinements in technique will change this aspect of the picture within a few years. At present, however, the most that can be said is that abnormal tracings are found both among psychopaths and non-psychopaths (but apparently more in regard to the former than the latter), and that the pattern of these tracings along with response to standard anti-convulsant medication would seem to indicate a possible relationship with some of the epilepsies.

Granting that abnormal tracings do appear among psychopaths, what does this have to say about etiology? As Silverman points out, " . . . not all persons who exhibit clinical evidence of damage to the brain have maladjusted personalities, and it is well known that 10 per cent of normal persons have abnormal brain waves. Similarly, many persons who encounter severe emotional trauma in childhood develop into presumably normal adults. In many psychopaths the cerebral dysfunction appears to increase the sensitivity to the emotional traumas of childhood."[23] And Lindner, who joins with others in calling attention to the psychopath's deviating "brain-wave patterns" and

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[23]Silverman, "Clinical and Electroencephalographic Studies on Criminal Psychopaths," p. 30.

"gross systemic responses," nevertheless warns: "But it must not be lost sight of that these differences may follow and not precede the appearance of the psychopathic syndrome."[24] Such statements should serve as a warning against making abnormal cortical activity the sole etiological factor.

Another reported etiological factor may be described as childhood psychic trauma or some inadequately resolved conflict occurring during childhood. Lindner's comment is especially noteworthy: "There seems to be little doubt that the special features of psychopathic behavior derive from a profound hatred of the father, analytically determined by way of the inadequate resolution of the Oedipus conflict and strengthened through fears of castration. Now since the father (or his surrogate) is the channel through which society -- construed in its broadest sense and including all precepts, commands and conditions for satisfactory social living -- is introjected, and since the father is hated and resented, the super-ego is correspondingly under-developed."[25] This position might be more logically tenable if all psychopaths were males. If the Oedipus conflict is basically one between son and father and daughter and mother, and if, as Lindner

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[24]Robert M. Lindner, Stone Walls and Men (New York: Odyssey Press, 1946), p. 156.

[25]Lindner, Rebel Without a Cause, p. 7.

maintains, the father stands for society, then how could an inadequate resolution of an Oedipus conflict apply to a girl to explain the condition?

Other factors which are said to be of etiological significance are social and cultural in nature. Wholey suggests that social conflict is an etiological factor because in his study of the inmates of a penitentiary he found that the psychopaths in the group he studied are more likely than non-psychopaths to have one or both parents of foreign birth.[26] At the same time he expressed his opinion that there was "little of importance in environmental factors" except "in activating any existing psychopathic trend."[27]

Lindner, in addition to espousing physiological and psychogenetic etiological theories, also expresses himself as convinced (in regard to the psychopath) that "there is no other way in which he can be described except by reference to the social order in which he happens to exist." He speaks favorably of "the proposition that psychopathic behavior is relative to the culture in which it flourishes and can be measured by no other rule than that of the prevailing ethic and morality. So in a society where total abstinence is mandatory -- as among

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[26]Wholey, op. cit., p. 57.

[27]Ibid., p. 58.

the Brahmins of India -- a sign of psychopathy would be inebriation; and, among the prostitute priestesses of Astarte, the persistent continence of a beauteous devotee consecrated to the distribution of erotic favors would indicate a psychopathic trend. In short, psychopathy is a disorder of behavior which affects the relationship of an individual to the social setting."[28]

While one can agree that "psychopathy is a disorder of behavior which affects the relationship of an individual to the social setting," there are other aspects of this approach by Lindner and some others which, if accepted uncritically, would almost certainly amount to a vast oversimplification of the matter. While the psychopath is notable for his rebellious attitude and behavior, it does not necessarily follow that everyone who deviates or even deviates significantly from the mores of the community is a psychopath. In regard to inebriation, even in a community where "total abstinence is mandatory," a number of factors would have to be considered before one arrived at the designation of psychopath. Rightly or wrongly, modern psychiatrists are in substantial agreement that the alcoholic is a sick person, but this does

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[28] Lindner, Rebel Without a Cause, pp. 1-2.

not necessarily mean psychopathic.[29]

Lindner's example of the priestess of Astarte must likewise be examined. To begin with, it is quite difficult to visualize a psychopath whose chief characteristic is continence! Even if, as Lindner proposes, continence were a symptom of rebellion against society, the example still would have to undergo further examination. Even in a culture which placed a premium upon incontinence, continence as such could result from a variety of conditions. The priestess instanced by Lindner might, for example, be homosexual rather than heterosexual in nature, thus finding it quite distasteful or even impossible to bring herself to have sexual relations with one of the opposite sex. There might also be the possibility of lack of sexual development, biologically speaking. Then too, one must not leave unconsidered the mental pathologies which might account for such a condition. Certain forms of schizophrenia, for example, at least in our culture, seem to occur in individuals who are not only unmarried but are also without sexual experience.[30] This is not to suggest

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[29]See, for example: Robert V. Seliger, "The Problem of the Alcoholic in the Community," American Journal of Psychiatry, vol. 95, no. 3 (Nov. 1938), pp. 701-713; Oskar Diethelm, Treatment in Psychiatry (New York: The Macmillan Company, 1936); Cleckley, op. cit.

[30]Concerning the schizophrenic, Abrahamsen writes: "His friendship seems rather superficial and simple, as does also his erotic life. His often complete coolness to sexual life, extending to utter platonism, is well known." (Op. cit., p. 99)

that the lack of marriage or lack of sexual experience is a factor in producing schizophrenia, but rather that a person with schizoid tendencies may be so lacking in even normal sexual feelings as to avoid sexual relationships. Furthermore, immediate gratification of the sexual appetite is one of the preeminent examples of living in terms of the pleasure principle rather than the reality principle as referred to previously. And immediate, or at least attempted immediate, gratification or all desires is a hall mark of the psychopath.

It would now appear in order to attempt to find some common ground, if possible, for these various points of view and to suggest an orientation for future research into etiology. Karpman makes a case for dividing psychopathy into two categories, the symptomatic and the idiopathic. Particular attention may be given to the following statement: "As the work of Maughs shows, there are many clinical pictures of different etiologies, which are included in the group of Psychopathy. They are as varied and far apart as different conditions could be. They have but one feature in common and that is they all display psychopathic-like reactions. That does not mean that they are genetically related -- in point of fact they are not -- it only shows that having different origins they have come to use a common pathway for their expression. It is this that has been the most stumbling block in the understand-

ing of Psychopathic States. For many psychiatrists interpret reactions that superficially seem to resemble each other as meaning that they had the same etiology, which, of course, is far from being the fact."[31]

It would seem, however, that one might go still farther along the road suggested by Karpman and instead of having merely a bilateral etiology, allow for the possibility of a number of etiological factors. In any event, it would seem to be time to stop attempting to explain psychopathy on the basis of one factor alone.

It may be appropriate to point out that the question of etiology hinges upon reasonably satisfactory diagnostic criteria. It is quite probable that many of the studies cited in regard to the etiology of the psychopath have included a number of non-psychopathic individuals. If the psychopathic syndrome can be made sufficiently clear and if competent diagnosticians can get to work on the problem, it should be possible to examine and study thoroughly from every possible angle a large number of true psychopathic offenders. In the meantime, it would seem wise not to allow etiological presupposition to be the determining factor in diagnosis.

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[31]Ben Karpman, "On the Need of Separating Psychopathy into Two Distinct Clinical Types: The Symptomatic and the Idiopathic," Journal of Criminal Psychopathology, vol. 3, no. 1 (July 1941), p. 120.

CHAPTER X

THERAPY IN PRACTICE

This chapter deals only with data gathered through the questionnaire-survey. We shall discuss, in order: the disposition of the psychopathic offender by courts and welfare agencies, the handling of the psychopathic offender in state mental hospitals and correctional institutions, and the extent of segregation of the psychopath from other patients or inmates of these institutions.

Disposition of the Psychopathic Offender by Courts and Welfare Agencies. The question asked was: "If a person is diagnosed as a psychopath prior to commitment or sentence, is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions? (a) general prison, (b) an institution for the insane, (c) an institution for the criminal insane, (d) other disposition (please specify what kind of other disposition)."[1]

In analyzing the answers to this question, the first effort was to determine whether the stated procedure was followed always or only sometimes. Only one of the thirty-three departments of welfare indicated that any given

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[1]Complete answers to this question are given in Appendix E-14.

procedure (in this instance, sending to a vocational school) was followed always. None of the sixteen independent juvenile courts stated any disposition of cases which was always followed. Out of sixteen combined juvenile courts, three stated that they sent the psychopathic offenders always to an institution for the insane, and two others indicated that the disposition was to a receiving home for children or to some kind of training school or reformatory. One other judge of a combined juvenile court made this comment as his standard procedure: "We muddle along trying to work out something with their families, friends, etc." It may be that such a statement would apply also to the practices of a number of others.

A majority of those on the circuit court and magistrate court level who answered this question indicated procedures of disposition which were followed always rather than sometimes. Of nineteen judges on the magistrate court level, two checked "an institution for the insane" and one checked "an institution for the criminal insane." Of forty-four circuit courts, nine checked "an institution for the insane," and six others checked "an institution for the criminal insane."

We consider next the disposition of these offenders that was reported as being followed sometimes (in contrast to always). Nine of the thirty-three departments of welfare indicated the following disposition:

Institution for the insane (8 times)
Training school, reformatory, or vocational schools (8 times)
Foster home (3 times)
General prison (2 times)
Institution for criminal insane (2 times)
Employment (1 time)
Study home (1 time)
Institution for feebleminded, if mentally retarded (1 time)

Eight of the sixteen independent juvenile courts indicated the following disposition:

Institution for the insane (6 times)
Industrial, training, or vocational school (6 times)
Undesignated institutions (2 times)
Institution for criminal insane (2 times)
Psychiatric clinics (2 times)
Detention home (1 time)
Hospital (1 time)
Other schools (1 time)
Boarding home (1 time)
Committment to other agencies for supervision or placement (1 time)
Remain in own home with continued psychiatric supervision (1 time)

Four of the combined juvenile courts indicated the following disposition:

Institution for the insane (2 times)
Industrial school (2 times)
Home for feebleminded (1 time)
Other institution (1 time)

Only two of the nineteen judges on the magistrate court level reported a disposition of these offenders which was followed "sometimes." One of these listed "general prison" and "care of relative," and the other checked "an institution for the criminal insane."

Five of the forty-four circuit courts reported:

Institution for the insane (3 times)
General prison (2 times)

Institution for the criminal insane (1 time)
Released on probation (1 time)
Referred to governor in capital cases (1 time)

The Handling of the Psychopathic Offender in State Mental Hospitals and Correctional Institutions. The following question sought to determine what happens to the psychopath after he arrives at a state mental hospital or correctional institution: "How are the psychopaths being handled in your institution? (a) the same as other patients (or inmates), (b) in a way different from other patients or inmates (please describe difference, if any)."[2] The results are summarized as follows:

Of ninety-five psychiatrists in state hospitals,[3] eighty reported that the psychopath was handled the same as other patients, while seven stated that he was handled differently. The differences noted were:[4]

Ground privileges or other liberty (3 times)
Closer supervision (2 times)
Given some responsibility (1 time)
Treatment individualized (1 time)
Placed in best quarters (1 time)
No ground parole privileges (1 time)

Thirty psychiatrists in correctional institutions[5] reported as follows: fourteen said that psychopaths were

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[2]Complete answers are given in Appendix B-15.

[3]Eight of these psychiatrists did not answer this question.

[4]Here and elsewhere it should be noted that one person often mentioned more than one of the following items.

[5]Seven of these did not answer this question.

treated the same as other inmates, while nine said they were treated differently. The differences were:

Segregation sometimes (6 times)
More closely supervised (2 times)
Frequent personal interviews (1 time)
Occupational therapy (1 time)
Music (1 time)
Individual room to sleep in (1 time)
Isolation at times (1 time)

Eight psychologists in correctional institutions indicated that in five institutions the psychopaths were treated the same as other inmates, and in three others that they were treated differently. The following differences were reported as occurring one time each:

More frequent interviews
Some psychotherapy
Different cell placing
Different work assignment
Special therapy for some

Out of replies received from twenty-seven superintendents of adult correctional institutions,[6] thirteen reported psychopaths treated the same as others, while six reported that they were treated differently. Individual treatment was reported twice, while the following differences in treatment were noted as occurring once each:

Special placement consideration
Employment program
Segregation
Isolation
Sometimes transferred to state hospital
Closer medical supervision
Given every chance to correct their condition

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[6]Eight did not answer this question.

Thirty-eight superintendents of juvenile correctional institutions[7] reported: psychopaths treated the same as others in fourteen institutions, treated differently in ten others. Differences in treatment were:

Some form of psychotherapy (3 times)
Special attention given to assignments (2 times)
Medication program (1 time)
More attention from clinic (1 time)
More personal attention (1 time)
Further study and some therapy (1 time)
Individual treatment (1 time)
Kept in segregation at night (1 time)

Extent of Segregation of the Psychopath from Other Patients or Inmates. A more specific aspect of the handling of the psychopath within institutions is covered in the following question: "In your institutions to what extent are psychopaths segregated from other patients or inmates? (a) not at all, (b) separate building, (c) separate wing of building, (d) separate floor, (e) any other type of segregation (please specify what kind)."[8]

The answers to this question are remarkably consistent in the frequency with which "not at all" is reported as the extent of segregation.

Ninety-five psychiatrists reported no segregation in eighty state mental hospitals, while three reported "sep-

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[7]Fourteen of these did not answer this question.

[8]Complete answers are given in Appendix E-16.

arate building," three "separate wing of building," and one "separate floor." Other types of segregation were listed once each as: "according to requirements of individual case" and "with convalescent patients."

Thirty psychiatrists in correctional institutions report: "not at all," twelve; "separate building," three; "separate wing of building," one; "separate floor," two. The following other types of segregation were given once each:

Separate rooms for about half of them when needed
Segregation in observation quarters in hospital during upsets
With other difficult patients
Allowed to go to own room when disturbed. Frequently hospitalized
Segregated if behavior problem.

Eight psychologists in correctional institutions reported no segregation from others in six instances and no other types of segregation except "careful selection of cell mates" and "worst cases segregated."

Twenty-seven superintendents of adult correctional institutions report: no segregation, sixteen; "separate floor," one; other segregation (one time each): "isolation room in hospital" and "sexual psychopaths placed where they are under close personal supervision -- frequently work in laundry."

Thirty-eight superintendents of juvenile correctional institutions report: no segregation, twenty-two; "separate wing of building," one; other segregation: "sepa-

rate school classification and classes" (listed once).

This lack of segregation does not necessarily reflect the desires or best judgment of many of those reporting. Two psychiatrists added the comments: "I feel they should be" and "Because of crowded conditions it is not possible to segregate these patients."

Some brief observations may now be made. In the first place, any interpretation as to the significance of the overwhelming evidence that the psychopathic offender is not treated differently from others would depend upon how others are treated. One psychiatrist who reported that the psychopaths were treated the same as others in his institution added the note: "i.e., each case is individualized, whether a psychopath or other diagnosis." General observation would indicate that this is a very rare practice indeed, and this observation may be supported by references to the instances in which individualized treatment was reported as the different way in which the psychopath was treated.

The wide distribution of factors listed in the description of difference in method of handling is evidently symptomatic of the general confusion existing among those who are entrusted with this responsibility. There are also some direct contradictions, such as "more closely supervised" versus "ground privileges or other liberty."

The difficulties involved in handling the psychopathic offender are underscored by a comment written in

the margin of the questionnaire by a psychiatrist in a state mental hospital: "Many times the psychopath handles us and requires far more daily supervision than the average psychotic person."

CHAPTER XI

PROGNOSTIC JUDGMENTS AND THERAPEUTIC IDEALS

The consideration of prognosis and therapy logically belongs together, for each of these holds implications for the other. From one point of view, it may be said that prognosis is derived from therapy, inasmuch as the success of past therapeutic efforts is the yardstick by which prognosis is measured. At the same time, the degree of favorableness or unfavorableness expressed in the prognosis is an indicator of the intensity of the therapeutic measures which must be applied.

In this chapter the prognostic judgments expressed in the literature and in the returns from the questionnaire-survey will be presented. These will be followed by the therapeutic ideals (in contrast to therapy in practice, as discussed in the preceding chapter) set forth by these two sources of information.

Prognosis in Current Literature. Most of the authors who deal with this topic[1] indicate an extremely poor prognosis for the psychopath. Outstanding in this respect is the study by Healy and Bronner.[2] Of fourteen juvenile

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[1]See Appendix D-3.

[2]William Healy and Augusta F. Bronner, Treatment and What Happened Afterward (Boston: The Judge Baker Guidance Center, 1939).

offenders who had been diagnosed psychopathic personality, only one had what is described as a favorable after-career.[3] Hulbert believes that "modification is tedious and slight if possible at all."[4] Karpman finds psychopaths "resistant to any attempt made to improve them,"[5] while Chornyak compares the condition to "inoperable carcinoma . . . ."[6] Cleckley finds it "much more disheartening than schizophrenia,"[7] and Hall finds psychopaths "peculiarly unamenable to discipline."[8] Maughs apparently agrees with "the commonly accepted belief . . . that the psychopath is untreatable."[9] Wittels notes that treatment and cure are "not as yet very efficient . . . ."[10] Darling finds the condition to be "of life-long duration in almost all cases,"[11] though later on he finds his out-

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[3]Ibid., p. 35.

[4]Hulbert, op. cit., p. 3.

[5]Karpman, "The Principles and Aims of Criminal Psychopathology," p. 203.

[6]Chornyak, op. cit., p. 1340.

[7]Cleckley, op. cit., p. 229.

[8]Hall, op. cit., p. 385.

[9]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," pp. 712-713.

[10]Wittels, op. cit., p. 215.

[11]Darling, op. cit., p. 125.

look changed "from one of pessimism to one of optimism."[12]

The most favorable prognosis is given by Wooley, who believes that the psychopath can learn "under proper training conditions . . . ."[13] Mangun believes it possible to change the attitude of the psychopathic offender through what he calls "therapeutic seclusion . . . ."[14]

Others take a kind of middle position between these extremes. Pargen finds that psychopathic offenders "lend themselves to routine and prove trustworthy, under disciplinary supervision."[15] Abrahamsen stresses maturation and subsequent social adjustment at the age of about forty-five.[16]

It is seen from this summary that the authors are by no means agreed as to prognosis, although the majority of them consider the condition to be well-nigh hopeless.

Prognostic Judgments in the Questionnaire-Survey. One method of guaging prognosis is to find out whether or not the psychopathic offender is considered to be a good

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[12]Darling, "Shock Treatment in Psychopathic Personality," Journal of Nervous and Mental Disease, vol. 101, no. 3 (March 1945), p. 250.

[13]Wooley, op. cit., p. 934.

[14]Mangun, "The Psychopathic Criminal," p. 121.

[15]Pargen, op. cit., p. 415.

[16]Abrahamsen, op. cit., p. 198.

probation and parole risk. The following questions were therefore asked: "Do you think the psychopath is a good probation risk?" and "Do you think the psychopath is a good parole risk?" In each case those answering the questionnaires were asked to check "Yes" or "No." Both of these questions were asked of all psychiatrists and state departments of welfare; only the question regarding parole was asked of administrative heads of correctional institutions, while only the question regarding probation was asked of the courts.[17] Table 15 summarizes the results.

It is thus seen that an overwhelming majority in almost every instance consider the psychopath to be a poor probation and parole risk. However, certain qualifying remarks were made, of which the following are typical: "Variable" -- "Depends on individual case" -- "If treatment is instituted early" -- "Under supervision" -- "Not unless he has recovered fully" -- "I doubt seriously if a true psychopath with anti-social traits should ever be discharged from an institution. He can no more change than a leopard can change his spots or an Ethiopian his color."

Another test of prognostic judgment was the question: "Do you think of the psychopath as representing modifiable

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[17] Complete answers to these questions are given in Appendix E-17.

TABLE 15. THE PSYCHOPATH AS A PROBATION AND PAROLE RISK

Source of Answers	Good Probation Risk?		Good Parole Risk?	
	Yes	No	Yes	No
95 psychiatrists in state mental hospitals	7	76	10	72
30 psychiatrists in correctional institutions	1	15	2	20
8 psychologists in correctional institutions			1	7
38 superintendents of juvenile correctional institutions			2	20
27 superintendents of adult correctional institutions			0	15
37 departments of welfare	2	9	2	9
16 independent juvenile courts	0	7		
16 combined juvenile courts	4	4		
44 circuit court level	3	15		
19 magistrate court level	3	3		

human material?" The range of suggested answers was: "Yes," "No," and "In part modifiable," with this last possible answer being subdivided into "To a slight extent" and "To a considerable extent."[18] This question was put to psychiatrists only.

Of the one hundred twenty-five psychiatrists answering the questionnaire, thirteen thought the psychopath modifiable, while eighteen thought not. Most of the answers fell

[18]Complete answers are given in Appendix E-18.

in the "in part modifiable" category: forty-seven reported that they considered the psychopath modifiable to a slight extent, while twenty-five considered the degree of modifiability to be considerable; one other psychiatrist checked both slight and considerable extent.

As in regard to most other answers, there were certain qualifications. One person thought that psychopaths could become "adjusted in the same manner that mental deficients can be." Another made the notation, "If one gets well, there was a possible mistake in the diagnosis." Variations of this assumption of the completely untreatable nature of the psychopath were expressed by two others.

Still another question relating to prognosis was asked of psychiatrists: "Have you ever known psychopaths to be 'cured'?"[19] In answering this question, twenty-eight of the one hundred twenty-five said "yes" and seventy-three answered "no." Those who answered that they had known psychopaths to be cured were asked, "What do you consider to be the salient factors in the cure?" The answers to this question may be summarized as follows:

Some form of psychotherapy (mentioned 9 times)
Maturation (8 times)
Modification of environmental factors (7 times)
Institutionalization (4 times)
Someone interested in patient's welfare (1 time)
Patience (1 time)

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[19] Complete answers are given in Appendix E-18.

Occupational therapy (1 time)
Prolonged habit retraining (1 time)
Reaction to a life crisis (1 time)

In summing up the opinions regarding prognosis, it is seen that the majority of those reported upon in both the current literature and the questionnaire-survey consider the prognosis to be poor. On the other hand, if even a minority are of the opinion that substantial changes can be made in the psychopath by various methods of treatment, this point of view cannot be ignored, to say the least.

Therapeutic Ideals in Current Literature. Appendix D-4 contains some of the therapeutic methods which authors have actually tried as well as those which they think ought to be attempted. These may be summarized as follows:

Some form of disciplinary training (mentioned by 6 authors)
Some form of psychotherapy (6)
Institutionalization -- of unspecified nature (3)
Environmental changes (3)
Time and patience (3)
Emphasis upon beginning treatment as early as possible (3)
Electroshock (2)
Specialized institutions with emphasis upon research or experimentation in methods of treatment (2)
Long-time segregation (2)
Permanent custody or supervision (1)
Treatment of parents (1)
Use of psychobiological principles -- but not psychoanalysis (1)
Community medical service (1)
Changes in educational system (1)
Occupational therapy (1)
Lobotomy (1)
Therapeutic seclusion and re-education (1)
Hypnoanalysis (1)
Anti-convulsant drugs (1)

Therapeutic Ideals in the Questionnaire-Survey. This topic was covered in the following question: "Do you think that the psychopath who commits a crime requires a method of treatment different from that required by other law-breakers? If so, what do you think should be the main points of difference in treatment?"[20] We consider first whether or not a different kind of treatment is recommended.

Representatives of thirty-three departments of welfare report: eleven think a different method of treatment is required, while two do not think so.[21] However, one of the two qualified his answer by saying, "Each case should be treated according to the diagnosis. The method is the same, but treatment in each case may be different."

Of twelve answers to this question from fifteen independent juvenile courts, all favor a different method of treatment.

In the combined juvenile courts eight of the sixteen answering think a different kind of treatment is needed, while one indicates otherwise. However, this one added the comment, "If treatment is based on welfare of child rather than criminal proceedings."

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[20]Complete answers are given in Appendix E-19.

[21]Here and elsewhere it is to be noted that several did not answer this particular question. However, throughout this study reference is made to the number answering the questionnaire as a whole, so that the reader may have available the data to evaluate the significance of failure to answer specific questions.

All eight of the judges on the magistrate court level who answered this question favor different treatment. Eleven did not answer.

Of forty-four officials on the circuit court level, twenty-two think a different kind of treatment is needed, while two think not.

For the thirty-eight superintendents of juvenile correctional institutions, twenty-three are in favor of different treatment, while three express themselves otherwise.

Out of twenty-seven superintendents of adult correctional institutions, fourteen report favoring different treatment, while one says he would favor different treatment only "during the periodic disturbances."

Seven out of the eight psychologists in correctional institutions favor different treatment, while one expresses himself as not in favor of different treatment.

Of thirty psychiatrists in correctional institutions, twenty-six think there should be different treatment. Another says, "Treatment is individual matter, not based on any diagnostic stereotype." Four say they are not in favor of different treatment. One of these explains himself by adding, "I do not feel that diagnosis per se is any index of basic dynamic problems. Especially is this true for such a variable, befogged category as psychopathy." Another of these expressed this point of view:

"If facilities, a specific program and specific treatment of proven value available it would certainly be justifiable and a very good investment to provide for the psychopathic group. Until we know more about the psychopath and discover some specific treatment, I think it advisable to carry on further studies in the field. Such studies should include different types of therapy for small numbers. In the meantime those who are accessible should have psychiatric treatment and those who experience mental episodes should be provided with hospital care."

Of ninety-five psychiatrists in state hospitals, sixty-three favor different treatment, while twenty do not.

Let us now try to interpret these answers. The first impression is, of course, that a large majority in all cases (with a smaller majority among the psychiatrists in state mental hospitals) favor a different kind of treatment for the psychopathic offender. However, it must be recalled that previous portions of this study showed an extremely limited knowledge of the concept, particularly among judges, many of whom equated psychopathy with psychosis or mental deficiency.

Some may feel surprise that as many as twenty psychiatrists in state mental hospitals are not in favor of different treatment for the psychopathic offender. One explanation of these answers might be that these twenty psychiatrists are really expressing their disapproval of

current procedures which so often eventuate in the unsatisfactory state of affairs reported in the opening paragraph of the present study. They may feel that is is better for the psychopathic offender to go on to prison, and thus be out of circulation for at least a while, than to be sent to a state hospital for a brief period, only to be released and to begin again his vast repertoire of offenses.

The next portion of this topic concerns the main points in the recommended different methods of treatment. These are so variable that any kind of summary presents difficulties. Nevertheless, certain items may be grouped together. It should be understood that in any summary of this sort it is out of the question to use all the words and phrases employed in the answers, but that the investigator must try to sense the underlying idea in the recommendations and report on these. The following summations show these factors (by groups reporting) in order of their frequency within each group. The numbers in parentheses refer to the number of times each factor was mentioned within any one group. Of course, in many instances more than one of these factors was given by the person answering this question.

State departments of welfare:
- Special institution (4)
- Psychiatrist experienced in dealing with this condition (2)
- Protective custody (2)
- Competent parole work (1)

Independent juvenile courts:
- Some form of psychotherapy (3)
- Protective custody (1)
- Specialized treatment and training (1)
- Psychiatric consultation with mother (1)
- Firmness (1)
- Time for establishing stability (1)

Combined juvenile courts:
- Some form of psychotherapy (4)
- Close supervision (1)
- Education of family (1)

Judges on magistrate court level:
- Psychiastrical [sic] (1)
- Special place of confinement (1)
- Some form of psychotherapy (1)

Circuit court level:
- Treated or imprisoned in institutions (3)
- Different kind of counselling (2)
- Close supervision (2)
- Work that he likes (1)
- Treated as sick (1)
- Operative procedures if necessary (1)
- Cure of mental ills (1)

Superintendents of juvenile correctional institutions:
- Continuing period of treatment (2)
- Different kind of institution (2)
- Special supervision (1)
- Individual care and guidance (1)
- Some form of psychotherapy (1)
- Protective custody (1)
- More sympathetic (1)
- Longer period within institution and special care (1)
- Special preparation for release (1)

Superintendents of adult correctional institutions:
- Psychotherapy (1)
- Segregation (1)
- Necessary medical treatment (1)
- Placed in smaller groups with more individual attention (1)
- Special institution (1)
- Avoid undue emotional stress (1)
- Close medical and educational supervision (1)

Psychologists in correctional institutions:
- Some form of psychotherapy (3)
- Longer period of treatment (2)

Without too much pampering (1)
As any other ill person (1)

Psychiatrists in correctional institutions:
Some form of psychotherapy (1)
Segregation (4)
Longer time (2)
Indeterminate commitment (2)
Special institution (2)
Close supervision (1)
More individual attention (1)
Keep occupied (1)
Isolation facilities (1)
More discipline (1)
Re-education (1)
Custody (1)

Psychiatrists in state mental hospitals:
Longer (or indeterminate) periods of confinement (12)
Some form of psychotherapy (11)
Close supervision (9)
Special institution (9)
Segregation (8)
Psychiatric approach (7)
Education or re-education (6)
Training (2)
Strict discipline (2)
Consider capacities and limitations (1)
Appeal to emotion (1)
Research into etiology (1)
Observation (1)
Industrial and occupational therapy (1)
Vocational training (1)
Rehabilitation (1)
Single sleeping rooms (1)
Treatment individualized (1)

Summary. This chapter has dealt with the closely related factors of prognostic judgments and therapeutic ideals as given in current literature and the questionnaire-survey. The preceding chapter discussed treatment as it is actually reported to exist in the hospitals and correctional institutions covered in the questionnaire-survey. By comparing present practice with the stated ideals, it should be possible to determine whether facilities for

adequate treatment are lacking among those who are aware of the need for distinguishing between the psychopathic and non-psychopathic offender.

In this chapter we have seen that a large majority of the psychiatrists in state mental hospitals and psychologists and psychiatrists in correctional institutions say they think that the psychopathic offender requires a method of treatment different from that required by other law-breakers. The forms of different treatment which they recommend most frequently are the following: longer periods of confinement or indeterminate sentence, special institutions, segregation (which might mean segregation in special institutions), and some form of psychotherapy.

The methods of treatment recommended most frequently by the authors reported upon in current literature are: some form of disciplinary training, some form of psychotherapy, institutionalization (of unspecified nature), environmental changes, time and patience, and emphasis upon beginning treatment as early as possible.

However, when we review the statements regarding present therapy in state mental hospitals and correctional institutions, we find that an overwhelming majority report that the psychopaths in their institutions are handled in the same way as other patients or inmates. Thus we find that even among those who realize the need for a different method of treatment of the psychopath very little opportu-

nity exists for such different treatment with the present facilities.

PART THREE

RECOMMENDATIONS

CHAPTER XII

DIAGNOSTIC CRITERIA

Up to this point in the study we have dealt principally with the present status of concept and practice as indicated by current literature and the questionnaire-survey. Among authorities (such as authors cited and psychiatrists in state mental hospitals and correctional institutions) and a few others there has been found general agreement that the delinquent and criminal population includes some who are designated as "psychopathic" and that this psychopathic offender is materially different from other kinds of law-violators. Beyond this there has been found a great deal of diversity and confusion. We have found that many "key" persons (such as officials of juvenile and criminal courts and superintendents of correctional institutions) who are entrusted with the responsibility for crime control lack minimal conceptual acquaintance, and hence are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. On the other hand, many of those who are aware of the need for making this distinction are decidedly lacking in adequate

diagnostic procedures and treatment facilities, and show marked disagreement in regard to diagnostic criteria.

Thus the portion of this study dealing with the stated problem has been concluded. It would be unfortunate, however, to conclude the study of so important a subject without making recommendations which attempt to point the way out of some of the confusion and diversity at present confronting us in regard to diagnosis and treatment. Therefore, the present chapter deals with recommendations for more adequate diagnostic criteria, while recommendations for diagnostic procedures and treatment will be made in the two following chapters.

The importance of clarifying the psychopathic syndrome is heavily underscored by such statements as the two which follow:

" . . . until we know more about the psychopathic personality, and . . . those using the term so frequently can better define it, then I am unwilling to attempt a treatment program for this particular type of individual that is very much different from any other maladjusted person. It seems to me that the term psychopathic is being applied so frequently, that certainly to me, it has little or no meaning, except that it indicates a blanket term, which in no way properly diagnosis the average individual who is placed in that category."

"The term 'psychopath' has been used so loosely,

particularly in the adult and juvenile delinquency fields as to make it practically a useless label. It is often used broadly by administraters of correctional institutions to refer to large groups of delinquents who are also psychotic or psychoneurotic; frequently the psychiatrists attached to or serving courts use it to describe individuals with confirmed delinquency patterns, and you will see in this connection the diagnostic label 'psychopathic personality without psychosis.' Attempts to define it narrowly with such descriptive terms as 'shallow emotional level,' 'lack of regard for consequences,' 'repetition of patterns leading to frustration,' and the like, have suffered by the existence of the looser, rag-bag type of definitions in wide use."

These statements were contained in personal letters to the writer and came, respectively, from the superintendent of a training school for boys and the director of a state department of welfare. Such comments, especially when added to the weight of the previous analysis of diagnostic criteria, raise the question as to whether it might not be better to toss this "waste basket" category, as some describe it, and all its contents into the scrap pile, and try to forget the whole bewildering business. Indeed, it is probable that the confusion in regard to concept is largely responsible for the tendency in some circles to discount diagnosis. Thus we find a juvenile court official saying: "In juvenile proceedings, the

necessity of clear-cut diagnosis is not necessary. -- Recommendations in planning more important from the judge's viewpoint."[1]

Such a point of view deserves examination. If the psychopath does not represent a distinct clinical entity -- if, in fact, all offenders are basically similar and respond equally well to the same type of treatment -- then, of course, it would be advisable to stop being concerned about definitions and diagnoses. On the other hand, if the psychopathic offender is somehow markedly different from others, and if many of the methods which work fairly well with others have little or no positive effect upon him, then this matter of "recommendations in planning" what should be done with him does indeed wait upon a knowledge as to the kind of offender with which the court or other agency is dealing. And this, of course, means that some kind of adequate definition or description of the condition is imperative.

It may be pointed out that in at least some pathological conditions the necessity for accurate diagnosis is almost universally recognized as prerequisite to recommendations for treatment. Examination reveals, let us say, the presence of some growth within the body. We need to know what kind of growth it is. In particular, is it cancer or is it something else which resembles it in cer-

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[1]Note on returned questionnaire.

tain aspects only? If careful diagnostic procedures reveal that the growth is benign in nature, recommendations of one sort are in order. On the other hand, if the growth should be diagnosed as malignant, measures of a different sort will almost surely be indicated. In the latter case, the measures called for may be far more drastic and vastly more urgent from the standpoint of immediate attention than in the case of a benign growth. Or again, certain aspects of the treatment of illness depend upon whether or not a given illness is diagnosed as communicable, which is to say whether the health of others is thereby endangered. In the case of communicable disease, quarantine or some other form of isolation from the community is often an important aspect of the general treatment program.

It would be strange indeed if psychopathy should be an exception to this necessity for accurate diagnosis in regard to pathological conditions generally.

Other portions of this study have called attention to the existing confusion and diversity in regard to the concept of psychopathy. This need not mean, however, that the concept is a worthless one and should be abandoned. It may mean, rather, that these diversities represent an attempt to circumscribe something which is really there. The circles drawn by the various authors may include or exclude too much, but most of them may have reference to a very real pathological condition. In any event, before anyone yields to the impulse to discard the concept, new

attempts ought to be made to crystallize the characteristic features of the syndrome, so that there may be some expectation that various diagnosticians will be reasonably agreed as to a working concept. This is not to imply that the matter should be settled once and for all, for such is not the lot of problems of human behavior. It is nevertheless believed that there can be found some method of diagnosis which will avoid the errors of diagnosing either by exclusion or on the basis of too limited a number of factors.

Ideally, this is a problem which should be studied by workers in such fields as psychiatry, psychology, anthropology, sociology, criminology, education, and religion. But particularly would it seem appropriate for psychiatrists, upon whom currently rests the major burden of diagnosis, to take the initiative in constituting a commission to study the problem of diagnosis and to formulate the syndrome just as clearly as possible.

A more immediate attempt to clarify diagnostic criteria seems possible on the basis of the material presented in this investigation. It is reasonably clear that a distinct condition does exist and that most of those who have written about this condition in the current literature are not altogether wrong. Therefore, it should be possible to say that points of agreement among workers in this field indicate, in the absence of contradiction with anything else that is known, a reasonable probability of accuracy -- or if not accuracy, then at least a greater degree of adequacy than

exists in the present over-all confusion. Where disagreements and contradictions prevail, some attempt at resolution ought to be made. Admittedly, such a procedure is not altogether satisfactory; but it is offered as the next step indicated in view of the present confusion, and it should prepare the way for some more adequate procedure.

The remaining portion of this chapter will attempt to present the criteria which must be considered in diagnosing psychopathy and to bring each characteristic of the syndrome into as sharp focus as possible, with particular attention to the delineation of these characteristics from both "normal" and non-psychopathic pathological conditions. Such a procedure assumes that the reader has already given careful attention to the preceding portions of this study, particularly Chapter VII, which dealt with diagnostic criteria in current literature.

A preliminary question concerns whether or not the approach should be made on the basis of certain "types," such, for example, as those given by Kraepelin, Kahn, or Schneider.

Cleckley, while discussing Kraepelin's seven types of psychopaths, comes to the conclusion "that the seven types appear, after all is said and done, remarkably alike, and it remains doubtful if any important or binding distinction has been made among them."[2] He represents

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[2]Cleckley, op. cit., p. 176.

himself as "strongly convinced that all the seven classifications employed by Kraepelin can be more properly applied as adjectives to all members of each class and that they are more valuable as being descriptive of the whole group than to distinguish between groups."[3] He offers it as his opinion "that the almost universal tendency of writers to separate a disorder vaguely and variously defined and explained into many, ever increasing and sometimes largely academic or trivial subtypes does not contribute to the understanding of this disorder by the ordinary student."[4]

Green also is moved to comment on the "many methods of classification by type." Pointing out that "their number and their points of difference cannot but reflect the general disagreement on the whole subject," he reports that "Carefully studied cases are usually found to overlap into two or more categories. An attempt to classify 100 markedly psychopathic patients at Springfield according to several of the methods was unsuccessful. Even when using the classification adopted by our Medical Center Staff, and believed best suited for our material, such a wide overlapping into different types occurred as to render it impractical."[5] He concludes by saying:

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[3] Ibid.

[4] Ibid., p. 200.

[5] Eugene W. Green, "Clinical Types of Psychopaths," Proceedings American Prison Association (1942), p. 107.

"Present day methods of classifying psychopaths, while often of administrative necessity, probably add more confusion than clarification, and have not proved practical in classifying a large number of cases at Springfield. For the present, therefore, it would seem wise to limit the diagnostic terminology to 'psychopathic personality,' perhaps qualified by degree as doubtful, slight, moderate, or marked."[6]

These considerations seem eminently valid. It would appear that anything which is a distinct clinical entity should present certain characteristics which would be present for any types, or subdivisions. If it should be decided at a later time that a subdivision into types is in order, such a procedure may properly be followed. For the present, however, it would appear that attention should be focused upon clarifying those characteristics which render this condition something sui generis.

We shall now proceed with the presentation of factors to be considered in making a diagnosis of psychopathy.

1. Variations from Normality. It seems self-evident that any distinct clinical entity must show variations from behavior which is described as "normal." It is not even adequate to speak merely of such characteristics as defective judgment, selfish, emotional instability, impul-

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[6] Ibid., pp. 107-108.

sive, and sexual deviations. These and any number of other similar terms might be used to describe people who are definitely not psychopathic.

In any attempted differentiation of abnormal versus normal, it is the part of wisdom to keep in mind Meyer's words: "It is, therefore, desirable that we should not expect hard and fast demarcations between normal and pathological, and between mental and non-mental . . . disorders. We recognize practical but not absolute lines of subdivision, as spheres of emphasis rather than thorough-going and distinct partitions."[7] The so-called "normal" person may have many of the same characteristics (such as phobias, mental "quirks," etc.) which are noticeable in the mentally disordered, except that in the first instance the person keeps these characteristics more or less under control, while in the latter instance these characteristics dominate and more or less control the person. The same situation, it may be noted, obtains in regard to crime: even the respectable citizen is not usually wholly law-abiding, but he manages to keep his criminal tendencies under reasonable control.

2. Differentiation from Other Forms of Abnormality. Even as any distinct clinical entity which falls within the realm of abnormality must be distinguished from what

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[7]Adolf Meyer, Lecture notes at the Henry Phipps Psychiatric Clinic, Johns Hopkins Medical School.

is called normal, it must also be differentiated from other forms of pathological behavior. This means that an adequate definition of psychopathy must delineate this condition with special care from those other conditions which appear to be like it in certain respects. This delineation will be attempted in regard to each characteristic rather than in regard to the condition as a whole.

3. Period in Life When Pattern of Behavior Becomes Discernible. In Chapter VII it was pointed out that agreement among psychiatrists was lacking in this respect, with most authors apparently making the very early beginning of this condition a weighty factor in differential diagnosis. It is possible that the felt necessity for such a very early appearance of the condition is dependent to some extent upon etiological formulations. Naturally enough, the person who insists upon an hereditary or constitutional basis for the condition could be expected to insist that the beginnings of the particular behavior pattern could be observed almost in the cradle, while the Freudians would be equally determined that the factors influencing the satisfactory or unsatisfactory resolution of the Oedipus situation would likewise show themselves at a very early age.

It is possible that some temporary freedom from etiological presupposition may admit of a later beginning

for the condition than is assumed in most cases. If it should be determined that certain acute infectious diseases or other marked disturbances within the organism could result in psychopathic behavior, it would hardly be possible to insist that the basic behavior pattern of the psychopath is present from an extremely early age.

It seems best, therefore, not to be too inflexible in regard to the age at which the pattern of behavior becomes discernible. Nevertheless, on the basis of the evidence presented by the various authors, it appears that most cases of psychopathy do manifest typical behavior patterns during childhood. It would not seem wise, however, to insist upon the presence of this characteristic if the picture should be otherwise complete.

4. Necessity for Longitudinal View. An important characteristic of psychopathy is that it is continuous rather than episodic, granting, of course, episodic disturbances in the continuum. Many of the other forms of mental abnormality, notably the manic-depressive psychoses, are vastly more episodic in character. Mental deficiency, of course, is continuous; and the same thing may be said for some of the psychoneuroses, which are often very long standing. However, differentiation from these conditions will be considered in regard to other characteristics of the syndrome.

5. Peculiar Power of Persuasion. There seems little

doubt that the psychopath, particularly if his intelligence is average or above, has a peculiar ability to talk himself into desirable situations and an equal facility for slipping out of undesirable ones. Whereas many other cases of abnormality would be suggestive of something obviously wrong after even very casual contact, the picture presented by the psychopath is more likely to be that of a super-salesman -- and the product he is selling is himself. This characteristic explains one of the reasons why people in general are so likely to be "taken in" by the psychopath and why they find it quite beyond their understanding to grasp the fact that such a smooth and frequently superficially attractive person can have anything mentally wrong with him.

A friend of mine has told me of walking through an old cell block in a prison. One inmate had remained in his cell while the others were playing ball outside. The prison official accompanying my friend asked, "Why aren't you playing?" The prisoner answered, "Oh, I just didn't feel like going out." Changing the subject rather abruptly, the prisoner asked, "Did you receive my request for an interview with you?" As he added, "Well, I would like to tell you something," my friend walked on. When my friend and the warden were together again, the warden said, in commenting upon this particular prisoner, "One thing about him is that after you talk with him a little while

you will be absolutely convinced that here is an innocent man being kept in the institution."

Whether or not this prisoner was psychopathic would be impossible to say on the basis of such fragmentary evidence, but this kind of ability to convince others of innocence -- or any other desired end, for that matter -- is truly characteristic.

Something approaching this same sort of ability may be found among individuals with a paranoid makeup. However, the paranoid who is definitely psychotic may buttress his arguments by hallucinatory and delusional material. He can put up a very convincing story as to just how and why he has been wronged and, like the psychopath, he is apparently unable to grasp the possibility that he may be wrong.

6. The Egocentricity of the Psychopath. While there seems general agreement that the psychopath is "selfish" and "egocentric," it must be pointed out that the same thing could be said about most mentally abnormal persons -- and indeed about many who fall within the range of normalcy also. It may be difficult to determine whether or not the psychopath presents a distinctive kind of egocentricity. The visit of Ibsen's Peer Gynt to the madhouse at Cairo may be cited in this connection. Peer had asked a doctor, Begriffenfeldt, director of the institution, whether or not the condition of the patients could be characterized as being "outside oneself."

Begriffenfeldt answered: "Outside? No, there you are strangely mistaken! It's here, sir, that one is oneself with vengeance; oneself, and nothing whatever besides. We go, full sail, as our very selves. Each one shuts himself up in a barrel of self, in the self-fermentation he dives to the bottom, -- and with the self-bung he seals it hermetically, and seasons the staves in the well of self. No one has ears for the other's woes; no one has mind for the other's ideas. We're our very selves, both in thought and tone, ourselves to the springboard's uttermost verge . . . ."[8]

The psychopath, along with many others who are mentally abnormal, presents this hermetically-sealed kind of selfishness. Apparently thoughts of what he wants entirely exclude any comprehension of the thoughts, desires, rights, or welfare of others. Thus, while the normal person may show rather extreme self-aggrandizing tendencies in regard to many aspects of life, there is usually some area in which he is generous or thoughtful or considerate in regard to others, particularly in close interpersonal relationships. The psychopath appears to have no such vulnerable spot in his armor of self. If he occasionally performs an act which might seem to spring from a generous motive, it would be the exception rather than the rule and could be properly shown to spring from motives

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[8]Henrik Ibsen, Peer Gynt, Act IV.

other than those which would indicate genuine concern for the welfare of someone else.

7. Relationships with Others. This attitude towards self would indicate that the psychopath regards others as suitable subjects for self-aggrandizement. Maughs would seem to be quite correct in his emphasis on the "ever recurring impulse to live at the expense of others without making any return . . . ."[9] It is to be expected, then, that the psychopath may be in rather frequent conflict with others -- others in the home, in the community, and in society at large. Anything anywhere which stands in the way of whatever desires he may have will almost surely represent a point of conflict.

8. Emotional Aspects. Probably all kinds of psychosis except cases of the occasional paranoiac (as contrasted with the paranoid) show disturbances of an emotional nature. The manic-depressive is outstanding in this respect, being characterized by marked elation at one time and equally marked depression at another. Although in such instances one occasionally sees rather rapid changes from the depths to the heights and vice versa, it is much more characteristic to observe episodes which are rather prolonged and which do not represent

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[9]Maughs, "A Concept of Psychopathy and Psychopathic Personality: A Dynamic Interpretation of Ten 'So-Called' Psychopaths," p. 515. See also other authors cited under section 21 in Chapter VII.

extremely rapid fluctuation from one mood to another. In the case of the psychopath, however, it appears that these changes in mood occur with great rapidity and without warning. Furthermore, they seem to be touched off by what the ordinary man would consider rather trivial causes.

The observation of Karpman that they "seem never faced with emotional conflict"[10] and the observations of others that they are without inner anxiety[11] should be considered in this connection. Perhaps such observations should be modified by saying that they appear to be without conflict or anxiety so long as they can have their own way. In this respect, they are similar to those criminals who are perfectly adjusted to the mores of their own cultural areas and believe that they are entirely within their rights in behaving as they do.[12] Therefore, whenever the examiner is confronted with an offender who appears to manifest no anxiety or sense of shame about what he has done, it would be of importance to determine whether or not he is acting in terms of the standards of the group with which he habitually associates.

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[10]Karpman, "The Principles and Aims of Criminal Psychopathology," p. 204.

[11]See section 6 in Chapter VII.

[12]See, for example, Thorsten Sellin, Culture Conflict and Crime (New York: Social Science Research Council, 1938), Chapter IV, and Clifford Shaw and Maurice E. Moore, The Natural History of a Delinquent Career (Chicago: The University of Chicago Press, 1931).

Like the offender of this "culture conflict" variety, the psychopath does frequently show anxiety when he is forcibly restrained from his activity. The outstanding example of such restraint is, of course, confinement in a prison or hospital. It appears, therefore, that a more accurate formulation of this aspect of the emotional life would be that the psychopath appears to show anxiety only when he is forcibly restrained or otherwise kept from having his own way.

In contrast to the psychopath, the psychoneurotic is riddled with conflicts and anxieties which are often easily detected.

Many maintain that the psychopath is entirely free from any feelings of guilt, remorse, or shame. Lippman reports the case of a girl analyzed by Mrs. Susan Isaacs of the Analytic Institute in London: "The case was described in a personal interview with Mrs. Isaacs, who had for a long time wanted to study a serious delinquent reported entirely to lack a feeling of guilt. The girl who was referred to her was fifteen years old and had committed almost every crime except murder. All methods of treatment had failed. She had been diagnosed a 'moral imbecile,' and seemed to have no social sense whatever. She was said to be entirely unmoved by what she did, had not the slightest wish to be given treatment, and was bored by the many attempts made to influence a change in behavior. She was placed in an institution for delinquent

young girls, and has been in analysis with Mrs. Isaacs for five years. The first two years she was brought by the matron to the analyst five times a week. She was very difficult and aggressive and on several occasions put her arms around the analyst and almost strangled her. She stole almost everything in the room during the first two years. Following this period she wanted to come alone and the analyst felt she could be trusted, and has been coming alone ever since. She is not entirely cured yet, but she is no longer dissocial. She still likes to carry on pranks and tease, but in other respects is quite a normal young lady . . . . She was amazed by the amount of anxiety that was found underlying this girl's delinquency. When the analyst after a long period of time was able to disclose this anxiety she found associated with it an overwhelming feeling of guilt. Mrs. Isaacs . . . has concluded that if this patient were capable of guilt feelings, few if any delinquents are free of such feelings."[13]

It would seem safe to say that the psychopath does not readily evidence feelings of guilt, and that if they are present at all, they are submerged in the deeper levels of consciousness.

Several of the authors have noted the lack of emotional tone or the shallow affect of the psychopath. The comment of Cleckley that they show "a readiness of expression

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[13]H. S. Lippman, "The Neurotic Delinquent," American Journal of Orthopsychiatry, vol. 7 (Jan. 1937), p. 120.

rather than a strength of feeling"[14] is significant.

Summarizing the emotional aspects of the psychopath, it may be said that marked and sudden variations in mood are found to be set off by what the normal person would consider to be rather trivial causes, that the psychopath appears not to manifest anxiety or emotional conflict except when restrained from his usual activity, in which case he is prone to go into psychotic episodes, and that the underlying tone of his emotional life impresses the observer as being more shallow than one would normally find.

9. Impulsive and Inhibitory Aspects. It is generally agreed that the psychopath acts on impulse and that inhibitory control is lacking to a degree which appears to be well-nigh absolute.[15] In this connection, it is often said that the psychopath knows or realizes the difference between right and wrong, but is unable to act in accordance with this knowledge.

When it is said that the psychopath "knows" the difference between right and wrong, presumably it is meant that the psychopath's "knowledge" consists of pure verbalizations rather than semantic comprehension. True enough, he may parrot moral maxims, and he may say that he

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[14] Cleckley, op. cit., p. 245.

[15] See sections 7 and 11 in Chapter VII.

knew it was wrong (or at least against the law) to commit the offense which led to his arrest. But certainly he does not know in the Socratic sense. It seems to me that Cleckley emphasizes a very important point in calling attention to the psychopath's "unawareness and a persistent lack of ability to become aware of the meaning-aspect of human life."[16]

The words "irresistible impulse" have been widely used to describe the psychopath. It does, indeed, seem quite clear that the psychopath often acts on impulse; an "impulse" strikes him, and he proceeds to act upon it. But just what is meant by "irresistible"? Does this use of "irresistible" carry with it the implication that some effort is exerted to oppose the impulse? If so, would not the results of this unsuccessful inner struggle show up in feelings of anxiety or guilt? But it is agreed that the psychopath is without normal inner conflict, anxiety, or feelings of guilt. And yet how can it be said that the impulses are irresistible unless one struggles to resist them and is finally overwhelmed?

Perhaps "unresisted" would be a more accurate description of the impulses of the psychopath. Certainly it appears that he usually makes no effort to resist his cravings. But some impulses apparently are resisted. Let us say that a certain psychopath who is walking along the

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[16]Cleckley, op. cit., p. 260.

street at night has a powerful impulse to break a jeweler's plate glass window and fill his pockets with watches and rings, but just as he gets ready to act upon this impulse a policeman appears. He then beats a hasty retreat or tries to cover up his intentions. Thus he does resist an impulse. It is indeed probable that the psychopath resists many impulses under certain circumstances.

It seems, therefore, that "irresistible" is too slippery a term to apply to the impulses of the psychopath. It would seem much more adequate to speak in terms of an imbalance between impulses and controls. What we observe clinically is that the psychopath habitually responds impulsively to a number of stimuli which the "normal" person would ordinarily control. It may not be possible to say at the present time whether this behavior results principally from strength of impulse or weakness of control or a combination of both, but the absence of inner conflict would strongly suggest a very marked weakness of inner controls.

An imbalance between impulses and controls is also found among psychoneurotics and psychotics. A psychotic person may have, let us say, a delusion that someone is trying to kill him. This delusion may be fortified by auditory hallucinations, and indeed the "voice" may instruct or, more properly demand, killing the would-be assassin. It is a notable feature in such instances that

the voice is accorded the utmost authority. It is beyond the domain of reason. Whatever the voice commands is to be accomplished at the first opportunity. Therefore, it is perfectly reasonable to say that such a person acts under the control of a powerful impulse. It is fairly simple to differentiate between the psychotic and the psychopath in this respect: The psychopath _qua_ psychopath is without delusions and hallucinations. It is true, of course, that a psychopath may become psychotic, in which case delusions and hallucinations would be present.

The psychopathic inbalance between impulses and controls may also be confused, on occasion, with the compulsion neuroses, one category of psychoneuroses in general. A familiar illustration of such compulsion is excessive hand-washing or repeatedly going to the door at night to see if it has been locked, or some other variety of ritualistic behavior. The person may frequently state that what he is doing is perfectly silly, and that he wishes he were not doing it, but that he cannot do otherwise. (Here we note inner conflict and anxiety, in contrast to the psychopath.) It is reasonable to ask whether some criminal behavior is of this compulsive variety, and the answer almost certainly would be in the affirmative. Familiar examples are the kleptomaniac and the pyromaniac.

Several of the authors already referred to have presented evidence to indicate that some behavior which is mistaken for psychopathy may in reality be the behavior

resulting from a psychoneurosis. A rather clear-cut example is the following case which Karpman presents:

"I am dealing here with a young adult male who seemingly out of a clear sky has given up a perfectly good position as a clerk to become a peddler or small wares. He would carry his bag with him and usually go through small towns and villages. He would come to a house, knock at the door and if a woman answered the door, he would try to sell what he had to sell. Every now and then, however, he would come to a house where the door would be opened by a little girl. He would ask her whether her mother was at home and when told that 'mother was out and will be back in an hour' he would say he wants to come in and wait for her. The little girl, unaware of the intentions of the man, would let him in. Within fifteen minutes rape would usually take place and the man would skip out before he could be apprehended and reported. Finally he was apprehended. He was brought to trial and received a death sentence. Because his people were rather prominent, they managed to secure the assistance of a very capable lawyer who maneuvered the case to be presented as a case of insanity. The man was pronounced 'not guilty by reason of insanity and mental deficiency' and was accordingly sent to the state hospital for mental defectives. Within a year the same lawyer took out a writ of habeas corpus, maintaining that the man had recovered his sanity. Our subject was accordingly released.

"One would suppose that having faced the electric chair once the man would have learned his lesson, but (apparently we are dealing with something stronger than reason), within a short time afterwards he was arrested again on the same charges. This time the District Attorney refused to compromise, but compromise he finally did by an agreement that the man leave the state. Our subject left the state and came to Washington. Surely one would believe that now the man has had all the lessons he needed. But it was not long after coming to Washington that he was arrested again on the same charge. By now he had the advantage of having been adjudicated insane and he was accordingly transferred to Saint Elizabeths. I had the opportunity to analyze the man which analysis brought a complete recovery. It's hardly possible for me to present the details of the case, but there was no doubt we were dealing here with a neurosis, a conditioned sex reaction, one of the major roots of which was traceable to a traumatic experience in his childhood when he himself was assaulted by an adult woman. This woman lured the little boy into her house, took him to her bedroom, pulled the shades down, locked the door and completely undressing herself, assaulted the boy. The large mass of pubic hair and the whole setting so frightened the little boy that it remained indelibly impressed upon his mind. When he reached adulthood, he would go after little girls because they had no pubic hair. Instead of going to a prostitute once a week, he would save

enough money to bribe the prostitute to shave off her pubic hair. It was really a pubic hair phobia. This has conditioned him not to deal with adult women but only with children. It is now close to 15 years since the man has been discharged from the hospital recovered. The latest reports are to the effect that he has not been in trouble since. One may reflect here that as an individual he was not deterred by the fear of death, that he was apparently under the influence of an irresistible impulse which was beyond any control that his intelligence could exercise. Though technically the man is called psychopathic personality without psychosis, there is no doubt that we are dealing here with a well established and well fixed neurosis."[17]

In distinguishing psychoneurotic behavior from that of the psychopathic offender, it should be kept in mind that the compulsion neurosis generally comprises one special compulsive act or one ritual comprised of several such acts. The kleptomaniac of today is not usually the firebug of tomorrow or the masochist of the day after. In the compulsion neurosis, these special forms of behavior fit into a regular and rather easily recognized pattern. The impulsive behavior of the psychopathic offender is of a different sort: one thing today and another the day

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[17]Ben Karpman, "Widening the Concepts of Insanity and Criminality," Journal of Criminal Psychopathology, vol. 4, no. 1 (July 1942), pp. 136-137.

after or even in the next hour. However, it should be recognized that the psychopathic offender may also exhibit psychoneurotic behavior of the kind described.

One other aspect of the imbalance between impulses and controls remains to be considered. The question may be put this way: Are there factors or conditions which predispose one to fall under the relative domination of impulses? If so, are these predisposants recent or remote? Sexual excitement may be a case in point. A great many people find that their sexual desires apparently get out of control after erotic stimulation. Alcoholic indulgence presents an analogous situation. Some people apparently lose control of their alcoholic appetite after even the first drink. In such cases, however, the predisposants are more or less recent in time to the diminishing of control, whereas in the case of the psychopath we find that such predisposants as may be discovered are much more remote in origin: his impulses are behavior patterns viewed longitudinally rather than impulses which can be traced to more or less recent predisposants.

It may very well be true that alcoholism, drug addiction, or socially unaccepted sexual practices form a part of the picture in the case of an individual psychopath; but no one of these taken by itself without a consideration of the other characteristics in the syndrome should be sufficient to place one in this category.

The nature of the imbalance between impulses and con-

trols of the psychopathic offender are in contrast to more or less normal behavior. Almost anyone may occasionally "lose control" of himself. One may, for example, become so angry that he passes over the threshold of self-control. In the case of the psychopathic offender, however, such behavior is habitual rather than occasional or spasmodic. It becomes a longstanding behavior pattern.

10. Intellectual Aspects. Persons who are mentally deficient are designated as feeble-minded, or as having less than normal native intelligence. They are classified as idiots (with a mental age of not more than three years); imbeciles (mental age four through seven years); and morons (mental age eight through twelve years). In addition to the feeble-minded, those who have a mental age of from thirteen through fifteen years are often spoken of as dull-normals.

Great is the confusion which sometimes results when the mental age or intelligence quotient (the I.Q.) of someone in difficulty becomes known. It is a familiar sight to see a social worker or teacher cling to a child's I.Q. like a drowning man to a straw, so great is the tendency to attribute all behavior difficulties to mental deficiency. The I.Q. is sometimes considered the only factor of any significance in understanding the delinquent, the criminal, or the failure in life. This tendency has been succinctly summarized by Richards: "Social worker, nurse, medical student, hospital intern when they hear an

intelligence quotient rating are apt to run off with it like a young dog with a bone, thinking that in this mental age rating they have the whole answer to the adolescent or grown-up behavior problem under consideration. The old dog chews on the bone, but hangs around to see if something else is coming that he needs to satisfy his hunger."[18]

Not only is mental deficiency, as indicated by psychometric tests, avidly seized upon as the explanation for behavior defects, but, contrarily, persons whose intelligence is indicated as being average or above are frequently, if not usually, assumed to be fully competent in all other respects if they are not psychotic.

It has been noted previously[19] that among authors cited the main point of disagreement in regard to intelligence is as to whether or not a person of below average intelligence should be diagnosed as a psychopath. We may consider also the data from the questionnaire-survey bearing on this topic.

The questionnaire sent to all psychiatrists asked: "Do you consider psychopathy to be distributed (a) through higher levels of intelligence? (b) through middle levels of intelligence? (c) through lower levels of intelligence?"[20]

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[18]Richards, op. cit., pp. 69-70.

[19]See section 24 in Chapter VII.

[20]Complete answers are given in Appendix E-9.

One hundred and one of the one hundred twenty-five psychiatrists who replied to the questionnaire answered this particular question. Nine of these indicated that they believed psychopathy is to be found only in the higher levels of intelligence, fifteen in the middle levels only, two in the lower levels only, seventeen in the higher and middle levels only, four in the middle and lower levels only, and one in the higher and lower levels; while fifty indicated that they believed psychopathy to be distributed throughout all levels of intelligence, and three others, instead of checking any of the possibilities listed, wrote in comments indicating that they believed the condition to be independent of or not directly correlated with intelligence.

By and large, the main point of disagreement is as to whether persons with below average intelligence can be classified as psychopathic. There is considerable reason to doubt the wisdom of excluding any level of intelligence in a consideration of psychopathy. As Healy points out: " . . . to designate an offender as mentally defective obviously does not tell the story of why he is an offender, when we realize that the vast proportion of morons are very decent, law-abiding citizens. Indeed, it has been proved that even after delinquent behavior has been shown, the after-careers of mental defectives are about as free from recidivism as are those of the mentally normal."[21] In a

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[21]Healy, op. cit., p. 69.

similar vein, Yepsen writes: "Generally speaking, the defective delinquent does have a relatively low level of intelligence, but a low level of intelligence is not the differentiating characteristic. The defect in personality is as important a differentiating characteristic in the group as a whole as is the low level of intelligence. It is not necessarily true that a single individual has both a low level of intelligence and a personality defect. The true mentally deficient offender is rarely a defective delinquent . . . .

"In his makeup, however, are the causative factors of crime. He is egocentric to a marked degree. He is non-inhibitive and suggestible when the action will affect him directly, but is resistive when he will not profit from the situation. He is limited in the cognitive field and generally is likewise limited in the field of intellect. Emotionally he is generally flat except in situations where he is the predominant actor when he displays a high and rapidly fluctuating emotional tone. He obtains his ends not on the basis of reason but on the basis of impulse."[22]

It seems in order to make the suggestion that the differentiation between psychopathy and mental deficiency must be made on some basis other than that of the I. Q. as

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[22]Lloyd N. Yepsen, "The Psychologist Looks at Crime," The Annals of the American Academy of Political and Social Science, vol. 217 (Sept. 1941), pp. 64-65.

determined by psychometric examinations. One point of differentiation from several of the psychoses would be that the intellectual powers are non-deteriorating in nature. Beyond that, one is impressed by what Lindner calls the "amazing excess-cargo of uncoordinated and useless information . . . ."[23] This sort of superficial brilliance may help to explain why the psychopath is often such an engaging conversationalist and why one is so frequently taken in by his tales without even considering it necessary to check on the accuracy of his statements.

11. Judgment. It is hardly enough to say that the psychopath has "defective" judgment, for such defect may characterize many of the other forms of mental abnormality. More particularly, judgment is often considered to be a defect of intelligence. However, it often happens that the person of relatively low intelligence has a kind of common sense which helps to keep him out of many serious difficulties. In contrast, the psychopath shows a kind of persistent "dumbness," as Richards[24] points out. This dumbness is not the sort which can be, or at least is, measured by intelligence tests, but it is one of the characteristics of the psychopath which seems to prevent his be-

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[23] Lindner, Rebel Without a Cause, p. 6.

[24] Richards, op. cit., p. 145.

coming a really "successful" criminal.

12. The Pleasure Principle and Life-goal. General agreement has been reported in regard to the fact that the psychopath lives in terms of the pleasure of the moment and that he seems to lack the ability to postpone immediate satisfaction for the sake of future rewards.[25]

This characteristic may explain what has been described as the poor judgment of the psychopath. If, as has already been pointed out, he is so sealed up within himself as to believe that the universe and everything in it exists for his own personal benefit, it would be entirely logical for him to seek what would appear to be immediate gratification in any respect whatsoever. This is not to say that everyone who is markedly hedonistic is psychopathic. The bon vivant finds it necessary, to a degree at least, to plan for his pleasure and hence to postpone immediate gratification in a number of instances. The ordinary man, while being no ascetic, would probably admit that even for the sake of pleasure itself a good many desires must be controlled or at least postponed in their fulfillment. The psychopath, however, shows a consistent lack of being able to wait, work or plan for any of his desires. It is this characteristic which suggests that any real life-goal is lacking.

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[25] See sections 17 and 18 in Chapter VII.

13. Capacity for Sustained Activity in Any One Direction.[26] It would naturally follow from the previous section that consistent yielding to the pleasures of the moment would make for exceedingly fleeting interests. If nothing is worth waiting for, then nothing is worth being pursued for very long at the time. The grass on the other side of the fence always looks greener; hence changing from one side of the fence to the other is to be expected. This kind of frequent change, with apparent inability to stick to any one activity for very long at the time, may show up in regard to residence, occupation, or job changes within any one general occupation. In milder forms of psychopathy, it is to be expected that even if the subject remains within one occupational field he may go off on periodic binges or wanderings in an attempt to relieve what is for him excessive tedium.

This characteristic of frequent change may show up in "normal" persons also. Rather frequently it takes some people a while to "find themselves," as the saying goes. In contrast, the psychopath seems never to find himself. And, strangely enough, the psychopath appears sure that a new position in life will solve all his problems, whereas the normal adolescent or young adult may not be at all certain that the new position which he is willing to try

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[26] See Section 19 in Chapter VII.

experimentally will solve his problem of vocational adjustment. Particularly in unsettled times the normal person who is in need of work may take the first job that comes along, and will consciously make use of every opportunity to "work his way up" through frequent changes as better positions become available.

Certain of the psychoses are also characterized by frequent change. The manic is unable to keep his attention on any one object for very long at the time; he is constantly busying himself, though not necessarily following only pleasurable pursuits. The markedly depressed person may likewise find it impossible to keep going in a consistent fashion on account of his feeling of general malaise. The paranoid may make frequent changes, but principally because of his belief that someone or something is after him or that he is otherwise endangered by remaining where he is, or because he believes he is not being treated fairly. In all of these conditions, however, in addition to such differences as have already been pointed out, is the fact that such frequent changes will occur during the prodromal period or after the onset of their illness rather than as a consistent pattern as in the case of the psychopath.

14. Resistance to Discipline. Marked disagreement in this respect has already been pointed out.[27] The question

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[27] See section 14 in Chapter VII.

may now be asked: If the psychopath is guided by the desires of the moment, if he seems incapable of postponing present satisfactions for future rewards, if in his eyes he is the sun about which the planets revolve, how can it be expected that he will take kindly to any sort of regimented existence, unless perchance he is doing the regimenting? This is not the same as implying that there is no form of discipline whatever which will have a wholesome effect upon him, particularly during the years before his pattern of behavior has definitely hardened; but it should indicate that the psychopath shows a decided resistance to the kind of discipline which is generally attempted and which proves more or less effective on normal persons. One should not infer, however, that a person whose behavior does not improve after a term in a reformatory or prison is a psychopath. The capacity for such institutions, as often conducted, to serve as a school for crime is too well known to admit of such a possibility.

15. Imperviousness to General Life Experience.[28] The normal person almost surely makes a number of mistakes during his lifetime, and occasionally he exercises "most execrable judgment." Generally, however, he discovers that some things work and that others do not. After a while he learns to choose the ways which work or which

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[28] See section 15 in Chapter VII.

otherwise bring desirable results. The psychopath apparently does not learn in this way, if at all. This is the burden of the oft-expressed statement that the psychopath "fails to learn or profit by experience." Wooley thinks that the psychopath has learned sufficiently to know how he can get his way with family and friends and others who indulge him. Even so, the psychopathic offender is likely to experience a good many hard knocks and other experiences which would have a severe chastening effect upon the average person. The psychopath, however, seems impervious to such experiences, even those most chastening experiences which bring sorrow or ruin upon loved ones. If we grant that the psychopath does not form tender and enduring attachments, we may understand something of the experience-repelling nature of his personality.

16. Super-ego Development and Functioning.[29] The psychopath is not the only person who appears to be without a conscience. Criminals of the "culture conflict" variety give an impression which is superficially similar. Still, in this latter case, however hardened the offender may be in regard to persons and situations outside his culture, he nevertheless has standards and a kind of conscience which operates very effectively within his own culture group. A knowledge of the background of the offender is imperative for a differential diagnosis in this

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[29]See section 28 in Chapter VII.

respect. Generally speaking, however, the psychopath shows a callousness and indifference that seems effectively to cover up whatever shame or remorse might reasonably be expected to exist in any normal individual; and this characteristic is noted not only in regard to society in the large but also in regard to any and all relationships which he might have.

17. Overt Acts. It has already been pointed out[30] that the psychopath may be expected to indulge in just about any sort of socially undesirable behavior. Since some specific act may generally serve as the reason for the psychopath's being brought to the attention of law-enforcement and treatment agencies, it would seem important to consider any special characteristics of the psychopath's behavior in this respect.

Although it is true that the psychopath may commit just about any sort of crime, he may hardly be expected to commit those which require very careful planning or considerable self-restraint. The professional criminal, as the name implies, makes a profession out of crime; and if he is to be successful, he must undergo a more or less extensive period of training. As Morris says, "One able second-story worker who has never owned a gun has for more than twenty years wintered in Florida and spent his summers in New England, carefully planning a limited number

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[30]See section 1 in Chapter VII.

of profitable jobs just before each seasonal migration.

"Such criminal businessmen regard imprisonment as one of the risks of their trade, and accept it without bitterness, as an undesirable but inevitable occasional interruption roughly comparable to hospitalization for a businessman who has become ill."[31] Any such skill, planning, and self-restraint would hardly be expected of the psychopath.

The psychopath's propensity for doing what he wants to do when and as he likes frequently shows up in his criminal activities, and sometimes results in his being caught. For example, one of the hard and fast rules among professional thieves is never to take anything "on the way out." That is to say, if they break into a jewelry store to rob a safe, they will do the job as expeditiously as possible and speedily be on their way, for they know that any delay will increase their chances of being caught. The psychopath, however, may go into a store to rob a safe, and on his way out will stop to pick up a few diamond rings in the show case.

The acts which a psychopath may be expected to commit are particularly those that appear to be without motive and those that give him immediate gratification or those which result when someone comes between him and the gratification

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[31]Albert Morris, "Criminals' Views on Crime Causation," The Annals of the American Academy of Political and Social Science, Vol. 217 (Sept. 1941), p. 141.

of his desires. In these acts unusual callousness, cruelty, or brutality may not infrequently be observed. Obviously, alcoholic over-indulgence and a wide range of sexual misadventures may be expected to be prominent in the activities of most psychopaths. Acts committed on impulse, without apparent regard for appropriateness or consequences, may be considered typical.

Finally, the psychopath may be expected to commit a number of <u>different kinds</u> of acts, even though he may specialize to some extent. Wherever one encounters a sort of ritualistic behavior or the repetition of a certain act in a particular way following rather exactly the same pattern, one may suspect a compulsion neurosis rather than psychopathy.

CHAPTER XIII

DIAGNOSTIC PROCEDURES AND FACILITIES

In large measure the importance of adequate diagnostic procedures and facilities is self-evident: regardless of how clearly the syndrome may be formulated, such a formulation will be of little practical value except as steps are taken to increase the probability that the psychopathic offender will be examined by a competent diagnostician. Therefore, it is the purpose of this chapter to present the broad outlines of a program for increasing at strategic points the number of examinations for psychopathy.

A primary recommendation is that the court procedure be divided into two parts. The first part of this procedure would be the guilt-finding phase, during which the attention of the court would be devoted to determining whether or not the accused is guilty. At present it would be highly impracticable, and perhaps undesirable from any standpoint, to seek to determine whether or not the defendant is a psychopath except in those instances where guilt is established.

The other phase of the court procedure would be the part given to passing sentence; and of course the passing of the sentence would involve, or at least should involve, a consideration of what ought to be done with the person

under consideration, both for his own good and for the good of society. It should be obvious from the material presented in this study that the nature of the sentence passed, or treatment ordered, would be vastly different for a psychopathic offender from what it would be for a non-psychopathic one. Therefore, the recommendation is that the time to examine for psychopathy is after the guilt-finding phase and prior to the sentencing phase of court procedure.

But which of the many persons found guilty should be examined for psychopathy? The nature of the offenses committed may help to provide a partial answer to this question. Although it has already been shown that the psychopath is likely to run the whole gamut of delinquency and crime, certain kinds of offenses or offenses committed in a certain way may be suggestive of psychopathy. Sexual offenses, crimes committed while under the influence of alcohol, crimes which appear to be without motive, and crimes in which particularly cruel or barbarous acts have occurred warrant special consideration in this respect. It is recommended that examination for psychopathy be made mandatory once a person has been found guilty of such offenses.

It has already been shown that the psychopathic offender is a person who has habitual difficulties with society. Therefore, any person who continues a career of

crime may be suspected of psychopathy. For this reason it is recommended that any person found guilty of three offenses (except minor traffic violations and similar technical offenses) be examined for possible psychopathy. Furthermore, in view of the fact that a large percentage of judges lack even the minimal conceptual acquaintance necessary for suspecting the condition,[1] there appears to be no alternative but to make the examinations mandatory instead of leaving this important matter to the discretion of the individual judge.

The matter of determining the number of offenses which any one person has committed involves certain difficulties. While some offenders continue to operate in a restricted area, many others range far and wide. The psychopath in particular may be expected to exceed the mobility of the general population. As a result, when the psychopath is apprehended for any given offense, the probability is great that his previous history will be unknown at the place where his most recent violation has taken place. And of course his own account of his past history cannot be trusted; indeed, he may be expected to give a very convincing story about this being the first time he has ever had any difficulty with the law. It therefore seems necessary to utilize some kind of central

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[1] See Chapter IV.

"clearing house" for the exchange of information about offenders. The national headquarters of the Federal Bureau of Investigation would seem the logical clearing house for such information. As it is well know, the FBI has on file a large number of fingerprints[2] and is accustomed to receive information from and supply information to police officials over the nation. The recommended procedure would therefore call for but few modifications of present practices. In reality it would be quite simple: Any offender found guilty by any court would be fingerprinted by the local police department. These fingerprints would then be sent immediately to the office of the Federal Bureau of Investigation in Washington, where they would be checked to determine whether previous offenses were on record. Any such fingerprints not already on record would of course be added to the Washington files, and in the course of time the fingerprints of all convicted offenders would be available for the procedure here recommended.

We must now consider the question, Who would make such examinations as are here recommended? Ideally, a psychiatrist or a psychologist, or both, should be attached to each court or, in some cases, to several courts in a given area. However, out of all the courts covered in this study, the only courts reporting either full-time or part-

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[2]The World Almanac for 1947 (p. 767) states that "at the end of the 1946 fiscal year there were more than 101,000,000 prints on file in the FBI in Washington, D. C."

time psychiatrists or psychologists were a few of the independent juvenile courts; others reported only specialists called in or specialists to whom cases were sent, and many reported no psychiatric or psychological services whatever.[3] Furthermore, there is little likelihood that this situation will be changed in the near future -- if for no other reason, because of the shortage of trained personnel. Obviously, therefore, in most instances we must look beyond the courts for diagnosticians.

One means of examining offenders for psychopathy is already available and needs only to be used. At present some psychopathic offenders are sent to mental hospitals for a period of "observation" after some violation of the law. The psychiatrist, however, is at present usually asked to determine only whether or not the person thus committed is "insane." It would be a very simple matter for the courts also to request information as to whether or not any person thus committed is psychopathic.

However, it should not always be necessary to commit an offender to a mental hospital in order to conduct an examination for psychopathy. In some instances the offender might be held in jail or prison until after the examination. Such examinations might be made not only by psychiatrists attached to mental hospitals and correctional

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[3]See Chapter VI and Appendix E-6.

institutions, but also by psychiatrists from medical schools and clinics, by clinical psychologists, and by members of the staff of university departments of criminology.

A further recommendation anticipates a portion of the next chapter, where it is proposed that treatment centers for psychopathy be set up on a regional basis. The relevance of these treatment centers to the present topic is that the psychiatrists or psychologists in these centers ought to be most expert in the diagnosis as well as treatment of psychopathy, and that they should re-examine every inmate upon his admission to their institution. In this way it is believed that the probability of wrongly diagnosing an offender as psychopathic would be reduced to a minimum.

It should be kept in mind that examinations for psychopathy would be made only if the offender has already been found guilty. If examination indicated that the offender was non-psychopathic, the time during which he was confined for purposes of examination would be deducted from the length of the sentence that would subsequently be imposed upon him.

As has already been pointed out in this study, accurate diagnosis of psychopathy seems to demand a rather extensive life history of the person being examined. In some instances the time and effort spent in gathering such a history may be considerable. Help in this respect

should be solicited from social workers of the department of welfare, probation and parole workers, and perhaps teachers and ministers.

We cannot leave this topic without calling attention to the fact that greater knowledge of the psychopath may quite possibly lead to some simpler method of diagnosis. Lindner believes that the Rorschach Test is valuable for diagnosis,[4] and Kutash finds similar value in the Thematic Apperception Test.[5] If there can be basic agreement as to what constitutes the psychopathic syndrome, and if there can be a sufficient number of psychopaths detected to make possible further extensive study of their nature and characteristics, it may very well be that some shorthand method of diagnosis, or at least some method of rough screening, may be developed.

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[4]Robert M. Lindner, "The Rorschach Test and the Diagnosis of Psychopathic Personality," Journal of Criminal Psychopathology, vol. 5, no. 1 (July 1943), p. 90.

[5]Samuel B. Kutash, "Performance of Psychopathic Defective Criminals on the Thematic Apperception Test," Journal of Criminal Psychopathology, vol. 5, no. 2 (October 1943), p. 339.

CHAPTER XIV

THERAPY

On the bottom of one of the returned questionnaires a psychiatrist wrote these words: "What are we going to do about them?" Obviously we cannot stop short of a careful attempt to answer this question.

Recommended therapy must take into account the present status of treatment. We have already seen[1] that most judges are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. From this fact it may be inferred that in most instances the convicted psychopath is sent to a general prison, reformatory, or training school along with non-psychopathic offenders. On the other hand, some psychopathic offenders find their way to mental hospitals, principally because they are committed for observation or because they have become psychotic. Thus practically all care or treatment of psychopaths seems at present to be limited to non-specialized correctional institutions and mental hospitals.

Once the psychopathic offender arrives at these correctional institutions or mental hospitals, he is treated, according to the great majority of reports given on

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[1] Chapter IV.

returned questionnaires, just like other prisoners or inmates.[2] If he is sent to a correctional institution, he returns to society after he has completed his sentence. If he goes to a mental hospital, he may gain his freedom even more quickly. Since mental hospitals may ordinarily not keep non-psychotic psychopaths longer than the time necessary for observation, and since the psychotic episodes of psychopaths frequently clear up rather quickly, we can understand the modus operandi by which psychopaths often escape both punishment and long-term treatment.

We have already noted[3] how prognostic judgments and stated therapeutic ideals are at odds with this picture of therapy in practice. If the many who report that little or nothing can be done to change the behavior of the psychopath are correct, then it is consummate folly to return this offender to the community. On the other hand, if others are correct in reporting that something can be accomplished by specialized treatment, it is obvious that psychopaths should not be released until after receiving such treatment. But at present the great majority of psychopathic offenders are receiving neither long-term custodial care nor treatment that is different from that given to other inmates or prisoners.

As we consider recommendations for treatment, the

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[2]Chapter X.

[3]Chapter XI.

procedure will be to examine the recommendations given in current literature and in the returns from the questionnaire-survey, giving particular attention to methods of treatment which are said to have resulted in cure or improvement.

In the questionnaire-survey the factors mentioned most frequently as resulting in cure or improvement were some form of psychotherapy and maturation. Closely following these in the number of times mentioned were environmental factors and institutionalization. The relationship of these factors to one another is not altogether clear. Certain questions arise: Was the psychotherapy provided in an institutional setting, or was this treatment handled privately? Furthermore, what is the relationship between institutionalization and maturation? Did the psychopaths mature <u>because</u> they were institutionalized, or would the process of maturation have continued at the same pace outside an institution? And just what were the environmental factors which brought improvement? Unfortunately, we do not have the answers to these questions.

Any enthusiasm about the efficacy of psychotherapy in the treatment of psychopathy must be tempered by the sobering report by Healy and Bronner on the results of psychotherapy at the Judge Baker Guidance Center. Despite intensive individualized treatment at the clinic as well

as envinronmental adjustments (such as foster home placements), Healy and Bronner report that only one out of fourteen psychopaths showed a favorable after career.[4] It is significant to note that this same kind of treatment proved highly successful on those diagnosed "extremely neurotic," of whom twelve out of fourteen showed favorable after careers.[5] But apparently the usual type of psychotherapy is not adequate for treating psychopathy. It may be that highly specialized techniques of depth analysis, such as the hypnoanalysis described in Lindner's Rebel without a Cause, are necessary if favorable results are to be achieved from the employment of psychotherapy. Even this cannot always be recommended. As Lindner himself points out, "Psychopaths can be treated, if at all, only by the systematic uncovering of the dynamic factors and events which precipitated the condition. Those in whom the attitudes have crystallized and the patterns have jelled are beyond any therapy. For these there is but one solution: recognition of the condition as a form of psychosis and subsequent removal from the community for detention purposes alone."[6]

Disciplinary training was also prominently mentioned

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[4]Healy and Bronner, op. cit., p. 85.

[5]Ibid.

[6]Lindner, Stone Walls and Men, p. 159.

as a recommended method of treatment. It has already been shown that many authorities consider any normal disciplinary training to be quite ineffective. Therefore, it would seem that any effective form of discipline must assume the nature of training which will allow the law of cause and effect to operate liberally and speedily. It has been stated earlier that many authorities consider that the psychopath does not learn or profit from experience. If experience of the disciplinary sort is to prove an exception to the general rule, it would obviously have to be much more consistently severe in nature and, presumably, would have to occur before personality patterns had become too inflexible. Thus Richards, while giving a very poor prognosis for the psychopath, nevertheless states: "Needless to say when one suspects a psychopathic personality in young childhood, no stone should be left unturned to give the boy or girl the best possible chance in habit training. If anything can help them to even a small measure of stability it must come through long periods of patient, consistent, day-by-day training procedures."[7]

Another recommendation which was frequently mentioned concerns the segregation of the psychopathic offenders and the establishment of special institutions for their

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[7] Richards, op. cit., p. 151.

care and treatment. It is abundantly clear that the usual type of institutionalization, whether in prisons or hospitals, is unsatisfactory. The suggestion that special institutions be established merits the most careful attention.

Such treatment centers would ideally be set up on a regional basis. One obvious advantage of a regional approach to the problem is that such inter-state cooperation should result in considerable financial saving. Of at least equal importance is the further advantage that such an approach ought to make it possible to secure the most qualified personnel to serve as members of the staff. But there is also the additional advantage that a number of institutions operated cooperatively or within one general system would make possible the development of institutions which specialize in various phases of the over-all treatment program. For example, it would almost surely be necessary to have one or more of these institutions in which maximum security would be a major consideration. Other treatment centers might well be graded according to the extent of responsibility placed upon and the degree of freedom allowed the inmates. If this were done, the transition from one kind of institution to another would be an important part of the therapeutic program, for it would show whether the psychopath being treated had improved to the extent that he could

accept any increases in responsibility and liberty. Furthermore, if it should become possible to return any of these psychopathic offenders to society, the transition would be a gradual one and should prove helpful in equipping them for the responsibilities and liberties of a citizen.

The other principal recommendation mentioned in current literature and the questionnaire-survey has to do with the length of the period of confinement. Many have pointed out that, if any improvement at all is to take place in the psychopathic offender, it occurs only after a considerable period of time. Some seem to feel that maturation, in and of itself, brings stability even for the psychopath. In any event, under present methods of treatment, long-term care is indicated. This would seem to imply the decided inadvisability of sentencing the psychopath for any definite length of time. The alternative would be the indeterminate sentence, which would operate the same as a commitment to a mental hospital and which would offer no more opportunity for abuses than is true of this accepted procedure in treating persons who are psychotic. Certainly the psychopathic offender should not be turned loose in the community until there is sufficient indication that he is able to meet life as a law-abiding citizen. Therefore, commitment would be necessary for the protection of society as well as a kindness to

the psychopath himself. In order to guard against all possible abuses and mistakes in diagnosis, it would appear that all psychopathic offenders should have their cases reviewed at regular intervals and that at least certain of these reviews should be made by competent officials outside the institutions in which they are confined for treatment.

If the psychopathic offender were committed to a psychopathic treatment center just as psychotic persons are committed to mental hospitals, there would be little occasion for anyone to feel that the psychopath is "getting by" without "paying" for his offenses. As a matter of fact, the time spent in treatment centers would probably exceed the length of time meted out in the usual sentences. But there would be this difference: in the treatment centers everything possible would be done to render the psychopath safe to return to society, and in the meantime society would be protected from his ravages.

In addition to committing the psychopathic offender to treatment centers for an indeterminate period, most careful follow-up procedures ought to be carried out for all who are released from the institutions. Such post-institution supervision ought also to be for an indefinite length of time.

It should be self-evident that the real <u>sine qua non</u> of any such program as is here recommended is competent

personnel to make the program function properly. This will necessitate using the most qualified persons presently available to initiate the program on a small scale and to train others who will become expert in treating the psychopathic offender. Such treatment centers as have been recommended should be utilized for at least a portion of the training of workers in this field.

The establishment of specialized treatment centers, staffed by competent personnel, should make possible intensive research into the etiology of psychopathy. That such etiological research is necessary is evident from the present picture of well-nigh hopeless confusion concerning etiological factors, as presented in Chapter IX. Furthermore, rational treatment presupposes knowledge of causes. Hence any procedure which increases knowledge of etiology is highly important as a recommendation which has implications for therapy.

Hand in hand with intensive research into etiological factors it is recommended that there be a liberal application of something analagous to "empirical medicine." In recent years much progress has been made (and much time saved) in the treatment of various psychoses by methods which seem independent of etiological formulations. The brain operation known as a prefrontal lobotomy is one of these methods. In this connection is it interesting to note that Banay and Davidoff report what they regard as a

favorable outcome of such an operation upon a psychopath: "Within three weeks after the operation, the compulsive drive of his obsessions ceased . . . . The patient gained insight and evidenced a newly developed ethical sense. From a social viewpoint he could be regarded as recovered."[8] Another empirical method of treating psychotics is known as shock therapy. Earlier methods of inducing shock were by the use of insulin and metrazol, but electro-shock therapy appears to be the method most frequently employed at present. In regard to the possibilities of using this method on psychopaths, it should be noted that Darling reports three instances in which electro-shock therapy was tried on persons who had been diagnosed as psychopathic, with favorable outcomes in two of the three cases.[9] Attention should also be given to Silverman's recommendation that sodium dilantin (an anti-convulsant drug) be tried in some instances where the electroencephalograph has revealed cerebral lesions.[10]

A final recommendation concerns Cleckley's statement

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[8]Ralph S. Banay and Leon Davidoff, "Apparent Recovery of a Sex Psychopath after Lobotomy," Journal of Criminal Psychopathology, vol. 4, no. 1 (July 1942), p. 65.

[9]Darling, "Shock Treatment in Psychopathic Personality," pp. 247-250.

[10]Silverman, "The Electroencephalograph and Therapy of Criminal Psychopath," pp. 439-466.

that "a profound reorientation of some sort is necessary."[11] It is quite possible that such a reorientation may be accomplished by methods other than those already suggested. We may note with considerable interest the fact that one of the psychiatrists reported upon in the questionnaire-survey gave "Reaction to a life crisis" as the salient factor in the cure of a case of psychopathy. We may note also what Wittels says about treatment -- "a complex and difficult task which cannot be successful without that almost magic component called love or grace or, more soberly and scientifically, transference."[12] When we consider the forces that may produce "a profound reorientation," we must include religion. Religious experiences have often resulted in the alteration of even very deeply rooted behavior patterns, as is evidenced by the material presented in such a study as William James' classic, The Varieties of Religious Experience.

It should be evident that the treatment of psychopathy calls for the application of such knowledge as is already available, intensive study, and careful experimentation in new methods while society is protected from the repeated ravages of this offender. It is difficult to see how this can be accomplished except through specialized institutions manned by a competent staff.

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[11] Cleckley, op. cit., p. 293.

[12] Wittels, op. cit., p. 216.

CHAPTER XV

SUMMARY

This investigation into the diagnosis and treatment of the psychopathic offender has utilized two principal sources of information: (1) current literature in the field and (2) a questionnaire-survey covering concepts and practices employed by a number of key persons in crime control agencies and institutions.

The problem was stated in terms of hypotheses which are believed to represent significant facts concerning the relationship between the psychopathic offender and the crime control agencies and institutions. The first of these hypotheses maintained that among criminals and delinquents there are some whom authorities in the field designate by the term "psychopath" or by some other roughly equivalent term. The most satisfactory evidence for testing this hypothesis is found in the reported incidence of psychopathy. In Chapter V we saw that such authorities as those cited in the current literature and psychiatrists attached to state mental hospitals and correctional institutions report on the percentage of psychopaths found in various correctional institutions and mental hospitals. Psychopaths in correctional institutions have obviously been convicted of some offense. Furthermore, at least

some of the psychopaths in mental hospitals (especially state mental hospitals) have been sent there by the courts after some alleged violation of the law. If authorities report any given condition (e.g., psychopathy) in terms of percentages among the law-violating population, it must necessarily be said that these authorities accept the fact of the existence of the condition.

The next hypothesis stated that authorities in the field are in general agreement that the psychopathic offender is materially different from other kinds of law-violators -- different from other kinds of mentally abnormal offenders as well as different from those who are considered not mentally abnormal. Several chapters contain information relating to this hypothesis. Chapter II surveyed the concept of psychopathy prior to the year 1935, the date which has been designated for purposes of this study as the beginning of current literature. The survey of this early literature indicates that the concept of psychopathy stemmed directly from concern about the question of responsibility for crime. Furthermore, this early literature indicates, despite marked variations in the characteristics of the condition as described by the various authors, a substantial stratum of agreement among most of the authorities: the condition is different from other forms of mental abnormality; it cannot be explained on the basis of intellectual deficiency; it is something

different from willful perversity and criminality; it has serious social consequences; in short, despite the areas of confusion and disagreement, the condition is considered to be something sui generis.

An examination of current literature also shows quite clearly that the authorities cited are in agreement regarding the fact that the psychopathic offender is different from other kinds of offenders and also different from other kinds of mentally abnormal persons. It is self-evident that the authors who discuss such aspects of the condition as incidence (Chapter V), symptomatology (Chapter VII), etiology (Chapter IX), prognosis and therapy (Chapter XI) consider the condition to be different from other categories. The same thing may be said also of such other authorities as are represented by the psychiatrists who answered the questionnaires sent out as a part of this study.

Another hypothesis was formulated as follows: many "key" persons in agencies and institutions entrusted with the responsibility for crime control are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders. In Chapter IV we examined the extent of minimal conceptual acquaintance on the part of those who answered the questionnaires. There is was seen that a number of such key persons as judges (on the juvenile court, circuit court, and magistrate court levels),

directors of state departments of welfare, and superintendents of juvenile and adult correctional institutions demonstrated a definite lack of minimal conceptual acquaintance by their answers to the questionnaire. If many of these persons do not possess even minimal conceptual acquaintance (i.e., if they equate psychopathy with "insanity" or mental disease in general or otherwise show that they do not know what a psychopath is) it must necessarily be said that they are not aware of the need for distinguishing between psychopathic and non-psychopathic offenders.

The final hypothesis maintained that many others, while aware of the need for distinguishing between the psychopathic and non-psychopathic offender, when considered as a whole are decidedly lacking in adequate diagnostic procedures and treatment facilities, and show marked disagreement in regard to diagnostic criteria.

Chapter VI dealt with the topic of diagnostic procedures and facilities as reported in the questionnaire-survey. The method followed was to examine the conditions under which a diagnosis of psychopathy is, or is not, made. Among the more significant findings are the following: In most courts psychopathy will go undiagnosed if the judge is not sufficiently well versed in the knowledge of this condition to order an examination. But we have already seen (Chapter IV) that most judges definitely lack, and nearly all probably lack, minimal conceptual acquaint-

ance, and hence would not order an examination. A diagnosis of psychopathy (if made) is not usually made until after admission to a state mental hospital or correctional institution. The psychiatrists and psychologists present a fairly consistent picture of diagnosing by mental examination and (sometimes) history. If a diagnosis is made in a correctional institution, it appears evident in a great many instances that the superintendent of such an institution must take the initiative in requesting an examination. In a number of instances no examinations of psychopathy are made in correctional institutions. The courts and welfare agencies indicate that diagnosis (if made) is likely to be made at almost any time between arrest and completion of sentence. Furthermore, psychiatric and psychological services available for courts and correctional institutions are meager, with a number reporting no services whatever available. Finally, a reported predominance of provision for re-examination in order to check the accuracy of the first diagnosis is qualified by the few instances in which regular intervals or consistent procedures for re-examination were indicated.

Chapter X discussed treatment as it is actually reported to exist in the hospitals and correctional institutions covered in the questionnaire-survey, while Chapter XI dealt with the closely related factors of prognostic judgments and therapeutic ideals as given in current

literature and the questionnaire-survey. By comparing present practices with the stated ideals, it should be possible to determine whether facilities for adequate treatment are lacking among those who are aware of the need for distinguishing between the psychopathic and non-psychopathic offender. It was seen that a large majority of the psychiatrists in state mental hospitals and psychologists and psychiatrists in correctional institutions say they think that the psychopathic offender requires a method of treatment different from that required by other law-breakers. However, when we reviewed the statements regarding present therapy in state mental hospitals and correctional institutions, we found an overwhelming majority reporting that the psychopaths in their institutions are handled in the same way as other patients or inmates. Thus we find that among those who realize the need for a different method of treatment for the psychopath very little opportunity exists for such different treatment with the present facilities. Furthermore, if the many who report that little or nothing can be done to change the behavior of the psychopath are correct, then it is hardly an adequate procedure to return this offender to the community. On the other hand, if others are correct in reporting that something can be accomplished by <u>specialized</u> treatment, it is obvious that it is not adequate procedure to release psychopathic offenders until

after they receive such treatment. But it has been shown that at present the great majority of psychopathic offenders are receiving neither long-term custodial care nor treatment that is different from that given to other inmates or prisoners. Hence it appears quite evident that present treatment is anything but adequate.

It was pointed out in Chapter V that the marked variations in the incidence of psychopathy reported by those who possess minimal conceptual acquaintance suggest that diagnostic criteria vary greatly. Diagnostic criteria were examined directly in Chapters VII and VIII. In Chapter VII the symptomatology presented in current literature was examined. In order to make a comparative analysis the author devised thirty-three symptomatological categories under which the various viewpoints could be presented and discussed. Considerable diversity of opinion was found in several important respects, especially in regard to the period of life when the pattern of behavior becomes discernible, the extent of self-control, the response to discipline or other external attempts at control, the intellectual aspects, insight, and the important negative factors in differential diagnosis.

In the analysis of diagnostic criteria employed in agencies and institutions (Chapter VIII) the same thirty-three symptomatological categories were employed. In this case, however, the categories were analyzed not for in-

ternal consistency (as in current literature) but for the number of these categories employed in each definition and for the specific categories which were used most frequently. This different kind of analysis of diagnostic criteria from these two sources was considered necessary because of the nature of the material with which we are dealing. Some of the authors cited in current literature discussed the psychopathic syndrome rather completely, whereas others discussed only certain aspects of it. The situation was quite different, however, in regard to the material in the questionnaire-survey. In every case, those receiving the questionnaire were asked, "What definition or description of the psychopath serves as a guide for diagnosis in your work?" The answers, therefore, could be assumed to contain all elements of the syndrome which were considered essential for diagnosis.

The analysis of these definitions revealed that most of those answering the questionnaire touched upon a relatively small number of categories. This would seem to indicate that one reason for the diverse diagnoses is that many diagnosticians employ too limited a number of characteristics in their diagnostic criteria. It was found, further, that there seems to be little agreement as to which of the categories (other than the one dealing with emotional aspects) are most important for psychiatrists in making a diagnosis of psychopathy.

It seems quite clear, therefore, that there is marked disagreement as to diagnostic criteria among those who are aware of the need for distinguishing between psychopathic and non-psychopathic offenders.

Part III of this study has dealt with the author's recommendations, for it was felt that the study of so important a subject would be incomplete without making recommendations which attempt to point the way out of some of the confusion and diversity at present confronting us in regard to diagnosis and treatment.

Recommendations regarding diagnostic criteria were set forth in Chapter XII. In many respects the clarification of the psychopathic syndrome is the most important present task. Correct etiological formulations, which are of prime importance for rational therapy, can be expected only as we have intensive research into the causative factors of a condition that is reasonably well defined. It was recommended, therefore, that students of human behavior, but particularly psychiatrists (upon whom currently rests the major burden of diagnosis), take the initiative in constituting a commission to study the problem of diagnosis and to formulate the syndrome just as clearly as possible. Attention is called, as a possible starting point, to this investigator's attempted clarification of diagnostic criteria as presented in Chapter XII.

Chapter XIII dealt with recommendations regarding

diagnostic procedures and facilities which are calculated to increase, at strategic points, the number of examinations for psychopathy. It was recommended, first of all, that court procedure be divided into a guilt-finding phase and a sentencing phase, and that examinations for psychopathy should be made after the guilt-finding phase but prior to the passing of sentence. It was further recommended that an examination for psychopathy be made mandatory for all who had been found guilty of as many as three offenses, and for certain others (such as sexual offenders) after having been found guilty the first time. It was shown that the number of offenses which any given person has committed could be determined by fingerprinting all convicted offenders and sending these fingerprints to the Washington office of the Federal Bureau of Investigation, where they would be checked to determine whether previous offenses were on record.

It was recommended that examinations for psychopathy could be made in mental hospitals by the simple expedient of requesting the hospital staff to report not only whether any offender committed for observation was "insane" (as is done at present) but also as to whether or not he is psychopathic. Other examinations for psychopathy could be made in the places of detention by psychiatrists from medical schools and clinics, by clinical psychologists, and by members of the staff of university

departments of criminology. Every offender found to be psychopathic by these examinations and subsequently sent to a special psychopathic treatment center would be re-examined by the experts attached to these institutions.

Recommended therapy was considered in Chapter XIV. A prime requisite would seem to be the establishment of regional psychopathic treatment centers, manned in all instances by the most competent staff available. The psychopathic offender should be committed to such treatment centers and kept there until it is safe for him to return to society, even as psychotic persons are committed to mental hospitals for an indeterminate period. In such treatment centers there should be application of such knowledge as is already available, intensive study, and careful experimentation in new therapeutic devices. In view of the present etiological confusion (Chapter IX), something analagous to "empirical medicine" would seem to be indicated even while conducting intensive research into etiological factors.

It may seem to many that this investigation has been of an unusually critical nature and that the results are by no means flattering to a large percentage of workers in the field of crime control. If such does indeed appear to be the case, it must be remembered that the first purpose of any scientific investigation is to determine the facts, however unpleasant they may be. The facts

presented in this study are important to society, and the sooner we know what the situation is the sooner we shall have opportunity to apply remedial measures. This investigation does not attempt to lay the blame for the present confusion at the doorstep of any particular persons or groups. Tremendous difficulties confront those who seek to deal with the psychopathic offender. It is understandable how in the past the study of this condition has lagged far behind that of other mental abnormalities. Considered as a whole, it is certainly true that the superintendents of state mental hospitals, particularly in recent years, have been tremendously overworked and have labored under many handicaps not of their own making. Unquestionably in many instances the psychiatrists have brought to their task a high degree of training and great fidelity to the trust placed in them. One of the most hopeful signs is that many of the psychiatrists themselves have expressed considerable dissatisfaction with the present status of the psychopathic syndrome and the treatment of the psychopathic offenders. Indeed, a great many have expressed themselves in favor of methods of handling the psychopath which could be made effective if the true nature of psychopathy were recognized in our legal codes.

Much of the solution to the problem of the psychopathic offender waits upon the development of an awareness of the nature and extent of the problem. Judges in particular, but all others in any phase of crime control

work also, need to know that the delinquent and criminal groups contain at least a sprinkling of psychopaths. In many instances this awareness is already latent. For example, one judge on the circuit court level indicated quite clearly, in a personal letter, that he equated psychopathy with insanity. At the same time he added, "The cases that give me the most trouble" are those shown in the report from the state mental hospital to be "not definitely insane but his conduct and the report shows that the accused is not normal." This judge even went so far as to say that "an institution to take care of this class of cases . . . would certainly be a wonderful help to society." A circuit court judge who is already acquainted with the concept wrote that the superintendent of a mental hospital in his state "had prepared and introduced in the legislature a bill recognizing psychopaths as a form of insanity and providing for their care and treatment in the hospital for the insane, which included sending such persons who were charged with crimes for treatment, but the bill was defeated. Personally, I think the bill, or one recognizing constitutional psychopaths as a form of mental sickness and providing for their care and treatment, should be adopted."

Such attitudes would seem to indicate that the problem of creating a greater awareness may not be as hopeless as some may assume. Even so, the psychopathic offender

presents a problem of the first magnitude, and it is a problem which cannot be solved by any one professional group alone. By all means, even such limited knowledge as we possess at present ought to be disseminated widely. Such groups as bar associations, mental hygiene societies, and criminology groups, as well as medical societies, need to be urged to place the problem of the psychopath upon their respective agenda. Medical schools, state departments of mental hygiene, and criminology study centers might well take the initiative in establishing a kind of "extension service" for those groups which can be interested in the problem. Another means of disseminating information is the publication of articles on this topic. Many articles are already being published in medical journals, as the bibliography at the end of this study indicates. But articles ought also to be written for numerous non-medical journals, so that the laymen who must have a large share in solving this broad social problem may become informed sufficiently to act intelligently in regard to it.

If Henderson is correct in saying that "there is no more urgent legal and medico-social problem"[1] than that presented by the psychopath, no time is to be lost in taking this problem to the people who must decide upon appropriate action.

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[1]D. K. Henderson, "Psychopathic Constitution and Criminal Behaviour," R. N. Craig et al, Mental Abnormality and Crime (London: Macmillan and Company, Ltd. 1944), p. 105.

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APPENDIX A

THE PSYCHOPATHIC CONCEPT PRIOR TO 1935

The material in Appendix A is arranged from the excellent historical study by Sydney Maughs, "A Concept of Psychopathy and Psychopathic Personality: Its Evolution and Historical Development."[1] Maughs' study includes several authors who are not included in this appendix; some of these fall in the period after 1935, and others, though publishing material prior to that time, have made such substantial contributions since that date that they are considered in those portions of the present study dealing with current literature.

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[1] Journal of Criminal Psychopathology, vol. 2, no. 3 (January 1941), pp. 329-356 and vol. 2, no. 4 (April 1941), pp. 465-499.

APPENDIX A-1

AUTHORS PRIOR TO 1935, ARRANGED ACCORDING TO APPROXIMATE DATE OF PRINCIPAL CONTRIBUTIONS

I. Latter Part of Eighteenth Century
- Ettmüller
- Pinel
- Esquirol
- M. Georget
- Rush

II. Early Part of Nineteenth Century
- Prichard
- Woodward
- Conally

III. Mid-nineteenth Century
- Kitching
- Jules Falret

IV. Latter Part of Nineteenth Century
- Bannister
- Gouster
- Bonfigli
- Savage
- Gasquet
- Hughes
- Tuke
- Kiernan
- Verga
- Michetti
- Morselli
- Buonomo
- Tamburini
- Lombroso
- Wiglesworth
- Benedikt
- Bleuler
- Martin Barr
- Nacke
- Koch

V. First Decade of Twentieth Century
- Adolf Meyer
- Hirsch
- Stedman
- H. W. Wright
- Steen

APPENDIX A-1

VI. Second Decade of Twentieth Century
- Charles Mercier
- Tredgold
- Karl Birnbaum
- B. Glueck
- Sandoz

VII. Third Decade of Twentieth Century
- Froukel
- Visher
- Thom and Singer
- Huddleson
- Augusta Scott
- Alice Johnson
- Henry Herd
- S. N. Clark
- Suttie
- Tredgold
- Cyril Burt
- Rees Thomas
- F. C. Shrubsall
- Scheetz
- H. M. Smith
- Bolisi
- Loren Johnson
- Winifred Richmond

VIII. Fourth Decade of Twentieth Century
- Andrew H. Woods
- Partridge
- Kurt Schneider
- Healy
- Eugen Kahn

APPENDIX A-2

TERMINOLOGY EMPLOYED BY AUTHORS PRIOR TO 1935

Terminology Employed	Author
Melancholie sans délire	Ettmüller
Manie sans délire	Pinel
Impulsive homicidal mania	Esquirol
Total perversion of the moral faculties	Rush
Moral insanity	Prichard, Woodward, Conally, Kitching, Jules Falret, Bannister, Gouster, Bonfigli, Gasquet, Hughes, Tuke, Verga, Michetti, Morselli, Buonomo, Lombroso, Wigglesworth (also used "congenital insanity"), Hirsch, Steen
Moral idiocy or moral idiotism	Woodward, Tamburini, Bleuler, Nacke
Moral imbecility	Kiernan, Tamburini, Charles Mercier, A. F. Tredgold, Henry Herd, Suttie, Rees Thomas, C. Shrubsall, H. M. Smith
Moral depravity	Benedikt
Moral paranoia	Martin Barr
Psychopathic inferiority	Koch
Psychic constitutional inferiority Constitutional inferiority	Adolf Meyer, H. W. Wright, Healy
Degenerative insanity of the moral type	Stedman
Moral weak-mindedness	Nacke
Psychopathic criminal	Karl Birnbaum

APPENDIX A-2

Terminology Employed	Author
Psychopath	B. Glueck, Huddleson, S. N. Clark, Bolisi, Loren Johnson, Scheetz, Winifred Richmond, Kurt Schneider
Psychopathic personality	Sandoz, E. Kahn, A. H. Woods
Constitutional psychopathic inferiors	John N. Visher, Thom and Singer, Augusta Scott, Alice E. Johnson
Moral defective	Tredgold
Temperamental deficiency	Cyril Burt
Sociopath	Partridge

APPENDIX B

COPIES OF THE QUESTIONNAIRE AND THE COVERING LETTER

APPENDIX B-1

COPY OF THE COVERING LETTER

U N I V E R S I T Y O F M A R Y L A N D
College Park

College of Arts and Sciences
Department of Sociology

Dear :

Dr. D. K. Henderson has recently said, "The place in civilized society of the person suffering from a psychopathic disposition or constitution has never been clearly defined, and yet there is no more urgent legal and medico-social problem."

Doubtless you agree with the import of Dr. Henderson's statement. Therefore, I believe you will feel the matter of sufficient urgency to fill out and return to me the enclosed questionnaire.

The answers to this questionnaire will constitute a part of a study covering the question of the detection and treatment of the criminal psychopath in the United States. A reply at the earliest possible date would be greatly appreciated.

A self-addressed, stamped envelope is of course enclosed.

Sincerely yours,

Archibald F. Ward, Jr.

APPENDIX B-2

QUESTIONNAIRE SENT TO PSYCHIATRISTS IN STATE MENTAL HOSPITALS

Please answer each question -- in most instances a check [✓] is sufficient.

If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

1. If a diagnosis of psychopath is made, is it made
   ☐ a. Prior to admission to your institution?
   What person or agency has responsibility for detecting and diagnosing the psychopath?_____
   ☐ b. After admission to your institution?
   How detected in your institution?_____

2. What percentage of cases within your institution in the year 1945 was diagnosed as psychopathic without psychosis?_____%
   What percentage diagnosed as psychopathic with psychosis?_____%
   (If figures are not available for 1945, please list in above spaces the percentage for the latest available year and state year here._____

3. How are the psychopaths being handled in your institution?
   ☐ a. The same as other patients.
   ☐ b. In a way different from other patients.
   (Please describe difference, if any.)

4. In your institution to what extent are psychopaths segregated from other patients?
   ☐ a. Not at all.
   ☐ b. Separate building.
   ☐ c. Separate wing of building.
   ☐ d. Separate floor.
   ☐ e. Any other type of segregation (please specify what kind).

5. Do you think that the psychopath who commits a crime requires a method of treatment different from that required by other law-breakers?
   ☐ a. Yes
   ☐ b. No
   If so, what do you think should be the main points of difference in treatment?

6. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   ☐ a. Yes
   At what intervals?_____
   ☐ b. No

7. To what other category do you consider the psychopath most closely related?
   ☐ a. Psychotics
   ☐ b. Psychoneurotics
   ☐ c. Feebleminded
   ☐ d. Any other (Please specify)_____

8. With what other category do you think the psychopath is most likely to be confused?
   ☐ a. By professional workers_____
   ☐ b. By laymen_____

9. Do you think of the psychopath as representing modifiable human material?
   ☐ a. Yes
   ☐ b. No
   ☐ c. In part modifiable
   ☐ To a slight extent
   ☐ To a considerable extent

(OVER)

10. Have you ever known psychopaths to be "cured"?
    - ☐ a. Yes
    - ☐ b. No

    If so, what do you consider to be the salient factors in the cure?

11. What is your opinion as to the etiology of the psychopath?
    - ☐ a. Unknown
    - ☐ b. Congenital
    - ☐ c. Inheritance
    - ☐ d. Physical disease (Please specify what kind)_____
    - ☐ e. Some kind of psychic trauma in childhood
    - ☐ f. Other etiological factors (Please specify)

12. Do you consider that there are degrees of psychopathy (as, for example, there are degrees of feeblemindedness)?
    - ☐ a. Yes
    - ☐ b. No

13. Do you consider psychopathy to be distributed
    - ☐ a. Through higher levels of intelligence?
    - ☐ b. Through middle levels of intelligence?
    - ☐ c. Through lower levels of intelligence?

14. Do you think the psychopath is a good probation risk?
    - ☐ a. Yes
    - ☐ b. No

15. Do you think the psychopath a good parole risk?
    - ☐ a. Yes
    - ☐ b. No

16. Do you consider that there is need for a better clarification of the psychopathic concept?
    - ☐ a. Yes
    - ☐ b. No

17. What definition or description of the psychopath serves as a guide for diagnosis in your work?

Name_____

Title_____

Institution_____

Address_____

APPENDIX B-3

QUESTIONNAIRE SENT TO PSYCHIATRISTS ATTACHED TO CORRECTIONAL INSTITUTIONS

Please answer each question -- in most instances a check ☑ is sufficient.

If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

1. If a diagnosis of psychopath is made, is it made
   - ☐ a. Prior to admission to your institution?
     What person or agency has responsibility for detecting and diagnosing the psychopath?_____
   - ☐ b. After admission to your institution?
     How detected in your institution?_____

2. What percentage of cases within your institution in the year 1945 was diagnosed as psychopathic?_____%
   (If figures are not available for 1945, please list in above space the percentage for the latest available year and state year here._____)

3. How are the psychopaths being handled in your institution?
   - ☐ a. The same as other inmates.
   - ☐ b. In a way different from other inmates.
     (Please describe difference, if any.)

4. In your institution to what extent are psychopaths segregated from other inmates?
   - ☐ a. Not at all.
   - ☐ b. Separate building.
   - ☐ c. Separate wing of building.
   - ☐ d. Separate floor.
   - ☐ e. Any other type of segregation (please specify what kind).

5. Do you think that the psychopath who commits a crime requires a method of treatment different from that required by other law-breakers?
   - ☐ a. Yes
   - ☐ b. No

   If so, what do you think should be the main points of difference in treatment?

6. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   - ☐ a. Yes
     At what intervals?_____
   - ☐ b. No

7. To what other category do you consider the psychopath most closely related?
   - ☐ a. Psychotics
   - ☐ b. Psychoneurotics
   - ☐ c. Feebleminded
   - ☐ d. Any other (Please specify)_____

8. With what other category do you think the psychopath is most likely to be confused:
   - ☐ a. By professional workers_____
   - ☐ b. By laymen_____

9. Do you think of the psychopath as representing modifiable human material?
   - ☐ a. Yes
   - ☐ b. No
   - ☐ c. In part modifiable
     - ☐ To a slight extent
     - ☐ To a considerable extent

(OVER)

10. Have you ever known psychopaths to be "cured"?
    - ☐ a. Yes
    - ☐ b. No

    If so, what do you consider to be the salient factors in the cure?

11. What is your opinion as to the etiology of the psychopath?
    - ☐ a. Unknown
    - ☐ b. Congenital
    - ☐ c. Inheritance
    - ☐ d. Physical disease (Please specify what kind)_____
    - ☐ e. Some kind of psychic trauma in childhood
    - ☐ f. Other etiological factors (Please specify)

12. Do you consider that there are degrees of psychopathy (as, for example, there are degrees of feeblemindedness)?
    - ☐ a. Yes
    - ☐ b. No

13. Do you consider psychopathy to be distributed
    - ☐ a. Through higher levels of intelligence?
    - ☐ b. Through middle levels of intelligence?
    - ☐ c. Through lower levels of intelligence?

14. Do you think the psychopath is a good probation risk?
    - ☐ a. Yes
    - ☐ b. No

15. Do you think the psychopath a good parole risk?
    - ☐ a. Yes
    - ☐ b. No

16. Do you consider that there is need for a better clarification of the psychopathic concept?
    - ☐ a. Yes
    - ☐ b. No

17. What definition or description of the psychopath serves as a guide for diagnosis in your work?

Name_____

Title_____

Institution_____

Address_____

APPENDIX b-4

QUESTIONNAIRE SENT TO SUPERINTENDENTS OF CORRECTIONAL INSTITUTIONS

Please answer each question -- in most instances a check [√] is sufficient.

If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

1. If a diagnosis of psychopath is made, is it made
   - [ ] a. Prior to admission to your institution?
     What person or agency has responsibility for detecting and diagnosing the psychopath?_____
   - [ ] b. After admission to your institution?
     How detected in your institution?_____

2. What percentage of cases within your institution in the year 1945 was diagnosed as psychopathic?
   (If figures are not available for the year 1945, please give percentage for latest available year, specifying what year).
   _____percentage psychopaths as of_____(year)

3. How are the psychopaths being handled in your institution?
   - [ ] a. The same as other inmates?
   - [ ] b. In a way different from other inmates?
     (Please describe difference, if any).

4. In your institution to what extent are psychopaths segregated from other inmates?
   - [ ] a. Not at all.
   - [ ] b. Separate building.
   - [ ] c. Separate wing of building.
   - [ ] d. Separate floor.
   - [ ] e. Any other type of segregation(please specify what kind).

5. Do you think that the psychopath who commits a crime requires a method of treatment different from that required by other law-breakers?
   - [ ] a. Yes
   - [ ] b. No

   If so, what do you think should be the main points of difference in treatment?

6. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   - [ ] a. Yes
     At what intervals?_____
   - [ ] b. No

7. Do you think the psychopath is a good parole risk?
   - [ ] a. Yes
   - [ ] b. No

8. What definition or description of the psychopath serves as a guide for diagnosis in your work?

(OVER)

9. If a handbook or other guide is used as a basis for defining and diagnosing the psychopath, please give title here_____

10. Is there a psychiatrist or psychologist available for your institution?

☐ a. Yes
- ☐ (1) Psychiatrist
  - ☐ (a) Attached to your institution full-time
  - ☐ (b) Attached to your institution part-time
  - ☐ (c) Specialist called in, or specialist to whom cases are sent
- ☐ (2) Psychologist
  - ☐ (a) Attached to your institution full-time
  - ☐ (b) Attached to your institution part-time
  - ☐ (c) Specialist called in, or specialist to whom cases are sent

☐ b. No

Your Name_____

Title or Position_____

Institution_____

Address_____

APPENDIX B-5

QUESTIONNAIRE SENT TO STATE DEPARTMENTS OF WELFARE

These questions refer to your work with juvenile delinquents only.

Please place a check mark in the square beside the statement which describes your practice, answering questions in accordance with the procedure in operation in your state.

1. Is there a psychiatrist or psychologist available for use in your work?
   - ☐ a. Yes
     - ☐ (1) Psychiatrist
       - ☐ (a) Attached to department full-time
       - ☐ (b) Attached to department part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
     - ☐ (2) Psychologist
       - ☐ (a) Attached to department full-time
       - ☐ (b) Attached to department part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
   - ☐ b. No

2. In your work, do you use the classification of "psychopath" or some similar term?
   - ☐ a. Yes
   - ☐ b. No

   If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

   If your answer to question #2 is "yes," please answer the following questions. But, in any event, please return the questionnaire.

3. If a juvenile is diagnosed a psychopath, at what stage in the proceedings is such a diagnosis made?
   - ☐ a. After case is brought to attention of authorities, but prior to the hearing (or trial).
   - ☐ b. During the hearing (or trial).
   - ☐ c. After hearing (or trial), but prior to commitment (or sentence).
   - ☐ d. After commitment (or after beginning to serve sentence).
   - ☐ e. At some other time (Please specify when).

4. If a juvenile is diagnosed as a psychopath prior to commitment (or sentence), is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions?
   - ☐ a. General prison.
   - ☐ b. An institution for the insane.
   - ☐ c. An institution for the criminal insane.
   - ☐ d. Other disposition (Please specify kind of other disposition).

5. After a case has been brought to the attention of the authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?

6. What percentage of juvenile cases brought to the attention of your department in the year 1945 was diagnosed as psychopathic?
   (If figures are not available for 1945, please give percentage for latest available year, and specify what year).
   _____percentage psychopaths for _____(year)

7. Do you think that the psychopath requires a method of treatment different from that required by other law-breakers?
   - ☐ a. Yes
   - ☐ b. No

   If so, what do you think should be the main points of difference in treatment?

(OVER)

8. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   ☐ a. Yes
   At what intervals?_____
   ☐ b. No

9. Do you think the psychopath is a good probation risk?
   ☐ a. Yes
   ☐ b. No

10. Do you think the psychopath is a good parole risk?
   ☐ a. Yes
   ☐ b. No

11. What definition or description of the psychopath serves as a guide for diagnosis in your work?

12. If a handbook or other guide is used as a basis for defining and diagnosing the psychopath, please give title here_____.

Name_____

Title or Position_____

Area served_____

Address_____

APPENDIX B-6

QUESTIONNAIRE SENT TO JUDGES OF JUVENILE COURTS

These questions refer to your work with juvenile delinquents only.

Please place a check mark in the square beside the statement which describes your practice, answering questions in accordance with the procedure in operation in your court.

1. Is there a psychiatrist or psychologist available for use in your work?
   - ☐ a. Yes
     - ☐ (1) Psychiatrist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
     - ☐ (2) Psychologist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
   - ☐ b. No

2. In your work, do you use the classification of "psychopath" or some similar term?
   - ☐ a. Yes
   - ☐ b. No

   If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

   If your answer to question #2 is "yes," please answer the following questions. But, in any event, please return the questionnaire.

3. If a juvenile is diagnosed a psychopath, at what stage in the criminal proceedings is such a diagnosis made?
   - ☐ a. After case is brought to attention of authorities, but prior to the trial.
   - ☐ b. During the trial.
   - ☐ c. After being found guilty, but prior to sentence.
   - ☐ d. After beginning to serve sentence.
   - ☐ e. At some other time (Please specify when).

4. If a juvenile is diagnosed as a psychopath prior to beginning to serve sentence, is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions?
   - ☐ a. General prison.
   - ☐ b. An institution for the insane.
   - ☐ c. An institution for the criminal insane.
   - ☐ d. Other disposition (Please specify kind of other disposition).

5. After a case has been brought to the attention of the authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?

6. What percentage of juvenile cases brought before your court in the year 1945 was diagnosed as psychopathic?
   (If figures are not available for 1945, please give percentage for latest available year, and specify what year).
   _____percentage psychopaths for _____(year)

7. Do you think that the psychopath requires a method of treatment different from that required by other law-breakers?
   - ☐ a. Yes
   - ☐ b. No

   If so, what do you think should be the main points of difference in treatment?

(OVER)

8. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   ☐ a. Yes
   At what intervals?_____
   ☐ b. No

9. Do you think the psychopath is a good probation risk?
   ☐ a. Yes
   ☐ b. No

10. What definition or description of the psychopath serves as a guide for diagnosis in your work?

11. If a handbook or other guide is used as a basis for defining and diagnosing the psychopath, please give title here_____.

Name_____

Title or Position_____

Area Served_____

Address_____

APPENDIX B-7

QUESTIONNAIRE SENT TO JUDGES ON THE CIRCUIT COURT LEVEL

Please place check mark in the square beside the statement which describes your practice, answering questions in accordance with the procedure in operation in your court.

1. A. Does the criminal law governing your court provide for a commission or special agency to pass upon the mental health of persons brought before your court on a criminal charge?
   - ☐ a. Yes
     - (1) By whom is this commission or agency designated?_____
     - (2) Of what professional groups is such a commission or agency composed?
       - ☐ (a) Physicians
       - ☐ (b) Lawyers
       - ☐ (c) Citizens without reference to their profession
   - ☐ b. No

   B. Is any other method available for passing upon the mental health of persons brought before your court on a criminal charge?
   - ☐ a. Yes
     Please describe this method here:

   - ☐ b. No

   C. If more than one method is available for your court, which of the above procedures do you generally follow?
   - ☐ a. Method described above under "A"
   - ☐ b. Method described above under "B"

   D. Does the criminal law in your state take account of any forms of mental illness except "insanity"?
   - ☐ a. Yes
     Please list such other forms of mental illness here:

   - ☐ b. No

2. Is there a psychiatrist or psychologist available for use in your work?
   - ☐ a. Yes
     - ☐ (1) Psychiatrist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
     - ☐ (2) Psychologist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
   - ☐ b. No

3. In your work, do you use the classification of "psychopath" or some similar term?
   - ☐ a. Yes
   - ☐ b. No

   If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

   If your answer to question #3 is "yes," please answer the following questions. But, in any event, please return the questionnaire.

4. If a person is diagnosed a psychopath, at what stage in the criminal proceedings is such a diagnosis made?
   - ☐ a. After case is brought to attention of authorities, but prior to the trial.
   - ☐ b. During the trial.
   - ☐ c. After being found guilty, but prior to sentence.
   - ☐ d. After beginning to serve sentence.
   - ☐ e. At some other time. (Please specify when).

(OVER)

5. If a person is diagnosed as a psychopath prior to beginning to serve sentence, is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions?

   ☐ a. General prison.
   ☐ b. An institution for the insane.
   ☐ c. An institution for the criminal insane.
   ☐ d. Other disposition (Please specify kind of other disposition).

6. After a case has been brought to the attention of the authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?

7. What percentage of cases brought before your court in the year 1945 was diagnosed as psychopathic?
   (If figures are not available for 1945, please give percentage for latest available year, and specify what year).
   _____percentage psychopaths for _____(year)

8. Do you think that the psychopath requires a method of treatment different from that required by other law-breakers?

   ☐ a. Yes
   ☐ b. No

   If so, what do you think should be the main points of difference in treatment?

9. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?

   ☐ a. Yes
      At what intervals?_____
   ☐ b. No

10. Do you think the psychopath is a good probation risk?

   ☐ a. Yes
   ☐ b. No

11. What definition or description of the psychopath serves as a guide for diagnosis in your work?

12. If a handbook or other guide is used as a basis for defining and diagnosing the psychopath, please give title here_____

Name_____

Title or Position_____

Area Served_____

Address_____

APPENDIX B-8

QUESTIONNAIRE SENT TO JUDGES ON THE MAGISTRATE COURT LEVEL

Please place a check mark in the square beside the statement which describes your practice, answering questions in accordance with the procedure in operation in your court.

1. Is there a psychiatrist or psychologist available for use in your work?
   - ☐ a. Yes
     - ☐ (1) Psychiatrist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
     - ☐ (2) Psychologist
       - ☐ (a) Attached to court full-time
       - ☐ (b) Attached to court part-time
       - ☐ (c) Specialist called in, or specialist to whom cases are sent
   - ☐ b. No

2. In your work, do you use the classification of "psychopath" or some similar term?
   - ☐ a. Yes
   - ☐ b. No

   If there is some other similar term which you use instead of "psychopath," please give that term here_____, and substitute that term for the term "psychopath" in the questions below.

   If your answer to question #2 is "yes," please answer the following questions. But, in any event, please return the questionnaire.

3. If a person is diagnosed a psychopath, at what stage in the criminal proceedings is such a diagnosis made?
   - ☐ a. After case is brought to attention of authorities, but prior to the trial.
   - ☐ b. During the trial.
   - ☐ c. After being found guilty, but prior to sentence.
   - ☐ d. After beginning to serve sentence.
   - ☐ e. At some other time (Please specify when).

4. If a person is diagnosed as a psychopath prior to beginning to serve sentence, is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions?
   - ☐ a. General prison.
   - ☐ b. An institution for the insane.
   - ☐ c. An institution for the criminal insane.
   - ☐ d. Other disposition (Please specify kind of other disposition).

5. After a case has been brought to the attention of the authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?

6. What percentage of cases brought before your court in the year 1945 was diagnosed as psychopathic?
   (If figures are not available for 1945, please give percentage for latest available year, and specify what year).
   _____percentage psychopaths for _____(Year)

7. Do you think that the psychopath requires a method of treatment different from that required by other law-breakers?
   - ☐ a. Yes
   - ☐ b. No

   If so, what do you think should be the main points of difference in treatment?

(OVER)

8. If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?
   ☐ a. Yes
   At what intervals?_____
   ☐ b. No

9. Do you think the psychopath is a good probation risk?
   ☐ a. Yes
   ☐ b. No

10. What definition or description of the psychopath serves as a guide for diagnosis in your work?

11. If a handbook or other guide is used as a basis for defining and diagnosing the psychopath, please give title here_____.

Name_____

Title or Position_____

Area Served_____

Address_____

APPENDIX C

NAMES OF COURTS

APPENDIX C-1

NAMES OF THE COURTS WITH WHICH JUVENILE COURTS ARE COMBINED IN THE VARIOUS STATES*

State	Court with Which Combined
1. Alabama	Probate court
2. Arizona	Superior court
3. Arkansas	County court
4. California	Superior court
5. Colorado	County court
6. Connecticut	No combined juvenile court
7. Delaware	Court of common pleas in one county
8. Florida	County court
9. Georgia	Other courts
10. Idaho	Probate court
11. Illinois	County and circuit courts
12. Indiana	Certain circuit and superior courts
13. Iowa	District court
14. Kansas	Probate court
15. Kentucky	County court
16. Louisiana	District courts and city courts
17. Maine	Municipal courts in cities Trial justice courts in towns
18. Maryland	Extremely varied
19. Massachusetts	District court
20. Michigan	Probate court
21. Minnesota	District court
22. Mississippi	Chancery court and sometimes circuit court
23. Missouri	Court of common pleas (one county) and circuit court
24. Montana	District court
25. Nebraska	District court, county court, police judge
26. Nevada	District court
27. New Hampshire	Municipal court
28. New Jersey	Court of common pleas
29. New Mexico	District court
30. New York	County judge
31. North Carolina	Clerk of Superior court
32. North Dakota	District court

*Arranged from data given in Directory of Probation Officers in the United States and Canada (New York: National Probation Association, 1941).

APPENDIX C-1

State	Court with Which Combined
33. Ohio	Probate and common pleas courts
34. Oklahoma	County court and one municipal court
35. Oregon	County court and circuit court
36. Pennsylvania	Municipal court (one) and quarter sessions elsewhere
37. Rhode Island	District court
38. South Carolina	Municipal court (one) and probate court elsewhere
39. South Dakota	County court
40. Tennessee	County court
41. Texas	District and county courts
42. Utah	No combined juvenile court
43. Vermont	Municipal court
44. Virginia	Trial justice
45. Washington	Superior court
46. West Virginia	Circuit court, common pleas court, intermediate court, criminal court
47. Wisconsin	Courts of record in each county
48. Wyoming	No juvenile court law. Questionnaire sent to judge of district court.

APPENDIX C-2

NAMES OF THE COURTS ON THE CIRCUIT COURT LEVEL*

	State	Name of Court
1.	Alabama	Circuit
2.	Arizona	Superior
3.	Arkansas	Circuit
4.	California	Superior
5.	Colorado	District
6.	Connecticut	Common pleas
7.	Delaware	Associate judge
8.	Florida	Circuit
9.	Georgia	Superior
10.	Idaho	District
11.	Illinois	Circuit
12.	Indiana	Circuit
13.	Iowa	District
14.	Kansas	District
15.	Kentucky	Circuit
16.	Louisiana	Circuit
17.	Maine	Superior
18.	Maryland	Circuit
19.	Massachusetts	Superior
20.	Michigan	Circuit
21.	Minnesota	District
22.	Mississippi	Circuit
23.	Missouri	Circuit
24.	Montana	District
25.	Nebraska	District
26.	Nevada	District
27.	New Hampshire	Superior
28.	New Jersey	Supreme
29.	New Mexico	District
30.	New York	Supreme
31.	North Carolina	Superior
32.	North Dakota	District
33.	Ohio	Court of common pleas
34.	Oklahoma	District
35.	Oregon	Circuit
36.	Pennsylvania	Superior
37.	Rhode Island	Superior
38.	South Carolina	Circuit
39.	South Dakota	Circuit

*Arranged from data given in Martindale-Hubbell Law Directory (Summit, N. J.: Martindale-Hubbell, Inc., 1946).

APPENDIX C-2

State	Name of Court
40. Tennessee	Circuit
41. Texas	District
42. Utah	District
43. Vermont	County
44. Virginia	Circuit
45. Washington	Superior
46. West Virginia	Circuit
47. Wisconsin	Circuit
48. Wyoming	District

APPENDIX C-5

NAMES OF THE COURTS ON THE MAGISTRATE COURT LEVEL*

	State	Name of Court
1.	Alabama	County court
2.	Arizona	Justice court
3.	Arkansas	County court
4.	California	Justice of the peace
5.	Colorado	County court
6.	Connecticut	Trial justice
7.	Delaware	Justice of the peace
8.	Florida	County court
9.	Georgia	City court
10.	Idaho	Justice of the peace
11.	Illinois	City and town courts
12.	Indiana	Magistrate's court
13.	Iowa	Municipal and superior (city) courts
14.	Kansas	City court
15.	Kentucky	Justice of the peace
16.	Louisiana	Justice of the peace
17.	Maine	Trial justice
18.	Maryland	Trial justice
19.	Massachusetts	Municipal court and district court
20.	Michigan	Justice of the peace
21.	Minnesota	Municipal court
22.	Mississippi	County court
23.	Missouri	Justice of the peace
24.	Montana	Justice of the peace
25.	Nebraska	County court
26.	Nevada	Justice of the peace
27.	New Hampshire	Municipal court
28.	New Jersey	Justice of the peace
29.	New Mexico	Justice of the peace
30.	New York	County court
31.	North Carolina	Recorders court and county court
32.	North Dakota	Certain county courts
33.	Ohio	Municipal court
34.	Oklahoma	County court
35.	Oregon	County court
36.	Pennsylvania	Court of quarter sessions

*Arranged from data given in Martindale-Hubbell Law Directory (Summit, N. J.: Martindale-Hubbell, Inc., 1946).

APPENDIX C-3

State	Name of Court
37. Rhode Island	District court
38. South Carolina	Magistrate's court
39. South Dakota	County court
40. Tennessee	Court of general sessions
41. Texas	County court
42. Utah	Justice of the peace
43. Vermont	Municipal court
44. Virginia	Trial justice
45. Washington	Justice of the peace
46. West Virginia	Justice of the peace
47. Wisconsin	County judge
48. Wyoming	Justice of the peace

APPENDIX D

THE PSYCHOPATHIC CONCEPT IN CURRENT LITERATURE

Throughout Appendix D the numbers in parentheses are page references for titles marked * in the bibliography.

APPENDIX D-1

SYMPTOMATOLOGY IN CURRENT LITERATURE

Year and Author	1. Overt Acts which May Occur as Prominent Features
1935	
Selling	Usually "a long record of behavior irregularities," not necessarily criminal (138) Dipsomania (138) Kleptomania (138) Lying -- "absurd stories" easily detected (139)
1937	
Wholey	More likely than non-psychopathic criminal to commit murder and robbery (57) Leave home earlier than non-psychopathic criminals (58) Sexual perversities (58)
1938	
Twitchell	Sexual deviations (422)
1939	
Henderson	Disorders of conduct of an anti-social or asocial nature (18) Behavior disorders usually of a recurrent or episodic type (18) May be suicides The gamut of sex perversions (75 ff)
Hulbert	Pyromaniacs (12) "Pathological liars" (15) Swindlers (15) Embezzlers (15) Kleptomaniacs (16) "Cranks" (17) Vagabonds (18) Suicide (11)
Mangun	"migratory" (308) "natural cheats" (308)
Pargen	"fabulous lies" (414)
Wilson and Pescor	"The nature of the offense committed is not a satisfactory diagnostic criterion since psychopaths show no partiality, their ungovernable emotions leading

APPENDIX D-1

Year and Author	1. Overt Acts which May Occur as Prominent Features (cont'd.)
Wilson and Pescor (cont'd)	them to crimes against the person and their lack of ethical sense to various offenses against property" (135)
1940	
Karpman	"ready liars and cheaters" (204) "excellent spenders" and borrowers (205) "many of the so-called habitual criminals . . . recruited" from this group (205) Several sexual deviations (204)
Noyes and Haydon	Often "conflict with the law" (212) "extravagant, often apparently purposeless lying, frequently combined with swindling." (214) "deviations of sex impulse" (212)
1941	
Caldwell	"Social delinquency" (171) "alcoholism or other addiction" (171) "Lying, often of a pathological nature" (172) Recidivism (171) Sexual deviations (171)
Chornyak	"uncontrolled in their sexual activity." (1331)
Cleckley	Alcoholic indulgence (247) Great promiscuity (253) "cheats and lies without any apparent compunction." (240)
Hall	"probably the biggest and the crudest liar of all" (784)
Richards	"running away" (145) "setting fires" (145) "sexual aggressiveness" (145) "bold stealing" (145) "the making up of dramatic stories in which he is the hero." (145) Lying, even in the face of substantial evidence against him (145)
Sprague	"disregard for truth" (915) Amazing "distortion of truth" (916)

APPENDIX D-1

Year and Author	1. Overt Acts which May Occur as Prominent Features (cont'd.)
1942	
Kaufman	"are always in difficulties" (129*) "have many and various schemes without logical basis" (129*) "oftentimes in conflict with the law." (129*) May make suicidal gestures (131) Includes "Most of the cases involving sexual delinquency" (131) Includes "many homosexuals, grotesque and pathological liars, vagabonds, wanderers, the inadequate and emotionally unstable, petty offenders, swindlers, kleptomaniacs, pyromaniacs, alcoholics, and . . . guardhouse lawyers" (129*) (Items marked * quoted from Circular Letter No. 19, March 12, 1941, Office of the Surgeon General, War Department, Washington, D. C., and apparently accepted by this author)
Mangun	Temper tantrums (117) Thievery (117) Lying (117) "Dislike for one or both parents" (117) "Truancy from school and home" (117) "Failure to get along with playmates" (117) "Unsatisfactory employment history" (117) "Strong migratory tendencies" (117) "restlessness, shiftiness" (117) "recidivism" (117) "Unsatisfactory adaptation to any environment" (118) "Tendency to assert 'rights' and be a troublemaker" (118) Sexual deviations (118)
Maughs	Life of swindling and fraud (494-501) "Inconsistencies" and "fabrications" (515) "extreme stubborness" (667) "recalcitrant behavior" (667) Clever fabrication (679) Recidivism (679) Some are continually in "hot water" (679)

APPENDIX D-1

Year and Author	1. Overt Acts which May Occur as Prominent Features (cont'd.)
Maughs (cont'd.)	Considerable "window dressing" (696) "continuous and repeated anti-social activity for intangible and illusory gains" (709) Alcoholism likely to be prominent (708) "Laziness . . . except in the fruitless pursuit of pleasure." (713) Lying (714)
Reichard	"always getting himself into trouble" (139) "criminal traits" (144) "vagabondage" (144) "sexual perversions." (144)
Statistical Manual	"prominent criminal traits" "vagabondage" "sexual perversions."
Wittels	"activities cover the entire scope of human behavior" (209)
1942	
Silverman	"unproductive, parasitic and antisocial." (19) "often total disregard for the truth." (19) "unprofitable, impulsive violent acts, temper tantrums or evanescent psychotic-like behavior." (19)
1944	
Abrahamsen	"aggressive" (111) "is in episodical or continual conflict with his surroundings." (111)
Lindner	Social rebel -- but "a rebel without a cause" (2) Nomadism (2-3) "frequently homoerotic or perverse in some other sense" (6)
1945	
Darling	"stereotyped deviations in the moral, social, sexual, and emotional components of the personality" (125)

APPENDIX D-1

Year and Author	2. Period in Life when Pattern of Behavior Becomes Discernible
1935 Selling	Irregularities "first noted in very early childhood" (138)
1939 Henderson	From the beginning or from a comparatively early age (18)
Mangun	"commonly found to have been intractable from a very early age" (308)
Pargen	"exists in all of them from the beginning . . . manifests itself at different times." (414)
1940 Noyes and Haydon	"a problem child" during childhood (212)
1941 Chornyak	Careful examination of entire life history necessary (1326)
Cleckley	Onset need not necessarily appear early in life (254-255)
Hall	Past history essential for diagnosis (385)
Richards	Manifestations appearing "early in life" (144)
1945 Darling	"develops before or during puberty" (125)

	3. Duration of Condition
1939 Wilson and Pescor	Must consider "individual's whole conduct from the age of puberty, or even before that," onward (135)
1941 Caldwell	"more or less life-long traits," (171)

APPENDIX D-1

Year and Author	3. Duration of Condition (cont'd.)
1942 Mangun	"recurring life pattern" (117) "Symptomatology more marked when subject is under thirty years of age" (118)
Wooley	"throughout life" (926)
1944 Abrahamsen	Thinks these offenders will "have a chance to mature and to adjust socially when they reach about forty-five." (198)
1945 Darling	"of lifelong duration in almost all cases." (125)
	4. Impressions Generally Made Upon Others
1939 Henderson	Insensibility and callousness (65)
Hulbert	Make good first impression (5)
1940 Karpman	"willful, stubborn, obstinate" (203)
Noyes and Haydon	"moody, impulsive, restless, unreliable, superficial, self-satisfied, opinionated" (213) "ready tongue, self-confident manner, a frequently assumed dignity" (214)
1941 Caldwell	"ingratiating and appealing behavior" (172) "a tendency to exaggerate, monopolize, disparage, criticize, dramatize, and pout." (172) "callousness" (172) "irritability" (172) "heedless, thoughtless, improvident" (172)
Cleckley	"usually a very attractive person superficially," making good first impression (279)

APPENDIX D-1

Year and Author	4. Impressions Generally Made Upon Others (cont'd.)
Hall	"frequently personally attractive and are often aided by superior physiques." (384)
Richards	Generally has excellent ability to sell himself (146)
1942	
Kaufman	"frequently he presents a favorable impression" (129*)
Mangun	"Immaturity of appearance" (118)
Wittels	"ingratiating" (209) "good actor" (212)
Wooley	"almost invariably superficially pleasant and likeable." (928)
1943	
Silverman	"on cross sectional review many psychopaths appear superficially intact, pleasant and likeable." (19)
	5. Attitudes in Regard to Self
1938	
Twitchell	"the ego shamelessly put in the foreground." (423) "selfish" (423) "conceited" (423)
1939	
Henderson	Self-assertive
Mangun	"self-centered" (308) "inflation of ego" (308)
Pargen	"egocentricity" (414) "boastful" (414)
1940	
Karpman	"utter and complete selfishness" (203)

APPENDIX D-1

Year and Author	5. Attitudes in Regard to Self (cont'd.)
Noyes and Haydon	"self-satisfied, opinionated" (213)
1941	
Cleckley	"egocentricity" in unusually large amounts -- an apparently absolute "incapacity for object-love" (241)
Chornyak	"complete egocentricity." (1326)
Hall	"egocentricity and incapability of real affection for others or of appreciation of their point of view, their right or their property" (385) "usually loves the limelight" (385)
Sprague	Feels "vastly superior to his fellow men." (915) "more self-centered than the ordinary individual" (916)
1942	
Mangun	"Egocentricity with ideas of self-importance" (117)
Maughs	"boastful and superior attitude" (515) "the desire to be important and the center of things" (515) "egotistical air of superiority" (713)
1943	
Silverman	"extremely narcissistic and selfish" (19)
1944	
Abrahamsen	"self-centered" (111)

	6. Emotional Aspects
1939	
Hulbert	"emotionally unstable" (9)
Mangun	"emotionally unstable" (308) Emotionally immature (309)

APPENDIX D-1

Year and Author	6. Emotional Aspects (cont'd.)
Wilson and Pescor	"Slaves of their emotions, their moods are as unpredictable as New England weather. Up in the clouds one day and down in the dumps the next." (132)
Pargen	"do not seem to have stability in their emotional fields" (414)
1940	
Karpman	"seem never faced with emotional conflicts" (204) "most primitive . . . emotional organization" (205)
Noyes and Haydon	Variations in emotion (212) "poverty of sentiment" (213) "moody" (213) "instability of emotions" (213) "explosive intensity of their emotions in reaction to relatively slight external stimuli." (213)
1941	
Caldwell	"Hair-trigger emotions" (172) "rapid swings from elation to depression for trivial causes" (172) "explosive and uncontrolled anger" (172) "Inconsistent worry" (172)
Chornyak	"extreme emotional instability" (1730)
Cleckley	"general poverty of affect"; may show "a readiness of expression rather than a strength of feeling." (245)
Hall	"emotional instability, swings of mood, temper tantrums and psychotic excitements" (385)
Menninger	"usually he is hyperagreeable, sometimes the reverse" (154)
Richards	"glaring emotional instabilities" "shallow, casual, almost cold-blooded in his emotional make-up." (146)

APPENDIX D-1

Year and Author	6. Emotional Aspects (cont'd.)
Sprague	"unbalanced and changing intensity of emotional response." (914)
1942	
Geil	"seems to lack the capacity to absorb emotional shock even in small quantities." (124) Functions "emotionally and mentally on a more primitive, egocentric, infantile level." (125)
Kaufman	"emotionally unstable" (129*)
Mangun	"Emotional instability from early age" (117)
Maughs	"without any deep emotional ties." (697)
Reichard	"emotional immaturity" (144) "emotional instability" (144)
Statistical Manual	Abnormal emotional reactions "emotional immaturity of childishness" "prone to . . . emotional instability with rapid swings from elation to depression, often apparently for trivial causes."
1943	
Silverman	"Affect is cold, humorless and lacking in qualities of genuine warmth, gratitude and remorse." (19)
1944	
Abrahamsen	"emotionally unstable." (111) Emotional immaturity and instability (112)
1945	
Darling	Deviations in "emotional components of the personality" (125)
	7. Impulsive Aspects
1935	
Selling	"characterized by the existence of the irresistible impulse." (138)

APPENDIX D-1

Year and Author	7. Impulsive Aspects (cont'd.)
1939	
Henderson	Behavior impulsive (46)
Mangun	"impulsive" (314)
Pargen	"impulsive" (414)
1940	
Noyes and Haydon	Variations in impulse (212)
1941	
Caldwell	"impulsiveness" (172)
Chornyak	"extreme . . . impulsivity" (1330)
Cleckley	Violent acts, when they occur, are usually casual, "done on impulse and without previous planning." (210)
Richards	Marked impulsive behavior (145)
1942	
Kaufman	"act impulsively with poor judgment" (129*)
Maughs	"extremely impulsive" (695)
Statistical Manual	"prone to impulsive reactions"
Szurek	"immediate gratification of whatever impulses happen to control them" (2)
Reichard	"impulsive activity without consideration of its consequences to himself or others" (144)
1943	
Silverman	"impulsive" (19)
1944	
Abrahamsen	"impulsive" (112)

APPENDIX D-1

Year and Author	8. Volitional Aspects
1939 Hulbert	Some are "the wilful perverse" (12)
1941 Chornyak	"a defect in the conative aspect of the personality." (1330)
1942 Statistical Manual	Abnormal volitional reactions

	9. Semantic Aspects
1939 Pargen	"realizes an act is wrong, comprehends its natural outcome, yet commits it just the same, not seeming to evaluate it." (414)
1940 Karpman	"no appreciation of the meaning of responsibility of any sort" (204) "unable to grasp the meaning and value of human life for others" (205-206)
1941 Chornyak	"sound sincere in their expressed desire to reform," but "continue to recidivate." (1332)
Cleckley	"total disregard for truth" and incapacity for understanding why others should value truth, yet expects his word to be accepted by others (239) "an unawareness and a persistent lack of ability to become aware of the meaning-aspect of human life." (260) Semantic dementia -- "mind or personality so damaged that experience as a whole cannot be grasped or utilized in its significance or meaning." (268)
Hall	"egocentricity and incapability of real affection for others or of appreciation of their point of view, their rights or

APPENDIX D-1

Year and Author	9. Semantic Aspects (cont'd.)
Hall (cont'd.)	their property" (385)
Sprague	"never able to make use of . . . verbal insight." (914)
1942	
Geil	"lack of capacity for experiencing genuine, sincere, sympathetic fellow-feeling; an inability to substitute, even temporarily, 'Social-Mindedness' for 'Self-Mindedness.'" (125)
1943	
Silverman	"Insight is usually absent, although one is sometimes confronted with superficial verbal insight." (19)
1944	
Lindner	"Psychopaths invariably show a naive inability to understand or appreciate that other individuals as well have rights; they also are inaccessible to and intolerant of the demands and pleas of the community, scornful of communal enterprise and spirit, suspicious of the motives of community-minded people or their representatives in public service." (7)
	10. Judgment
1935	
Selling	"the commission of acts which can serve no purpose or benefit the individual in any way" (138)
1939	
Mangun	"defective judgment" (309)
Pargen	"an absolute lack of judgment" (414)
1941	
Caldwell	"Lack of judgment" (172)

APPENDIX D-1

Year and Author	10. Judgment (cont'd.)
Chornyak	"peculiar lack of judgment" (1732)
Cleckley	"most execrable judgment," throwing away what the ordinary man would regard as excellent opportunities (240)
Hall	"defective judgment" (385)
Menninger	"take chances and run risks that the normal person would not." (154)
Sprague	"failure to give adequate consideration to consequences." (913)
1942 Kaufman	"act impulsively with poor judgment" (129*)
Reichard	"defective judgment" (144)
Statistical Manual	"marked defects of judgment"
	11. Extent of Self-control
1935 Selling	"irresistible impulse." (138)
1939 Hulbert	"inability to abide by previous decisions" (8)
Mangun	Knows "right from wrong," but "appears quite incapable of doing the right." (308)
1940 Karpman	"Crude gratification of instincts and indulgence in appetites in the most primitive sense" (203)
1941 Chornyak	Quoting another psychiatrist: "the lid is off the id." (1331)

APPENDIX D-1

Year and Author	11. Extent of Self-control (cont'd.)
1942 Szurek	"Unable to inhibit or to postpone action, or to acquire satisfactions in culturally acceptable ways." (2)
Wooley	"lack of inhibitory control" (930)
1944 Abrahamsen	"unable to control their emotional strivings." (111)
Lindner	No "brake" upon behavior (5)
	12. Degree of Trustworthiness
1939 Pargen	"prove trustworthy, under disciplinary supervision." (415)
1942 Wittels	"completely faithless" (212)
	13. Response to Kindness or Special Consideration
1939 Mangun	"Kindness appears to be wasted on" them (309)
1941 Cleckley	"little of the ordinary responsiveness to special consideration or kindness." (247)
	14. Response to Discipline or Other External Attempts at Control
1939 Henderson	Behavior difficult to influence by methods of social, penal, or medical care and treatment (18)

APPENDIX D-1

Year and Author	14. Response to Discipline or Other External Attempts at Control (cont'd.)
Mangun	"incorrigible" (308)
Otis	"During the World War we had no trouble with psychopaths in the Army . . . ." (417)
Pargen	"vast majority make good patients or convicts" (415) "lend themselves to routine and prove trustworthy, under disciplinary supervision." (415)
1940	
Karpman	"resistant to any attempt made to improve them." (203) Punishment of no help (206)
Noyes and Haydon	"Neither persuasion nor punishment is of avail." (212) "unresponsive to training, discipline or treatment." (213)
1941	
Caldwell	"a lack of amenability to correction, discipline, or reward" (171)
Cleckley	"no punishment will make the psychopath change his ways." (241)
Hall	"peculiarly unamenable to discipline." (385) "the Army is no place for such persons, who later become expensive." (386)
1941	
Richards	"unamenable to training processes of home and school." (144)
1942	
Griswold	"The crux of the situation resolves itself into one fact. Men suffering from this disorder should be prevented from joining the Navy." (649)
Kaufman	"Disciplinary action is usually of no avail." (136)

APPENDIX D-1

Year and Author	14. Response to Discipline or Other External Attempts at Control (cont'd.)
Szurek	"inability to modify their behavior despite usually educative experiences" (2)
1943 Silverman	"As an indication of the psychopath's inability to get along under a repressive environment, 68 of the 75 patients repeatedly violated institutional rules and had to be kept under strict supervision in order to prevent them from violating rules or disturbing the morale of other inmates." (21)
1944 Strecker	"in World War I the lesson was thoroughly learned that the constitutional psychopathic inferior cannot by any of the devices of psychiatry be made adequate for military service. It seems unfortunate that this lesson had to be expensively and sadly relearned in World War II." (407)
Van Vorst	" . . . this study gives definite evidence that the psychopath has a more difficult adjustment problem in an institution, and also constitutes a more difficult case to handle than does the ordinary delinquent who may parallel him in some personal characteristics and home background. Not only does it take him longer to earn his release, but he is also involved in more offenses, both petty and serious, necessitating disciplinary action. It is particularly in regard to very serious offenses, where a hazard to the physical safety of himself and others is concerned, that he constitutes the greatest problem." (493)
	15. Response to General Life Experience
1939 Hulbert	Continued repetition of the same behavior (5)

APPENDIX D-1

Year and Author	15. Response to General Life Experience (cont'd.)
Wilson and Pescor	"Personal experience, no matter how bitter or beneficial it may be, teaches them nothing; neither can they draw any adequate conclusions from the experience of others." (131-132
1940 Karpman	"neither learn from experience nor remember the lesson." (206)
1941 Caldwell	"inability to learn by experience" (172)
Chornyak	Failure "to profit by experience." (1329)
Cleckley	"inability to learn or to profit by experience, however chastening his experiences may be." (240)
Hall	"inability to profit by experience" (385)
Richards	Seeming inability to learn from experience (1946)
Sprague	"does not learn effectively from even repeated experiences." (913)
1942 Geil	"never seems to learn or to profit through experience." (125)
Kaufman	"manifest a definite defect in their ability to profit by experience." (129*)
Mangun	"Failure to learn from experience" (118)
Maughs	Failure to learn by experience (706)
Reichard	"seems to be unable to learn by experience" (139)
Statistical Manual	"without evidence of learning by experience"
Wooley	"they continue to carry out behavior patterns which seem to profit them little

APPENDIX L-1

Year and Author	15. Response to General Life Experience (cont'd.)
Wooley (cont'd.)	and irritate their fellow men, even though such behavior has at times caused themselves injury." (929) They have "learned from experience" sufficiently to know that family and friends protect and indulge them (929)
1945 Darling	"lack of . . . ability to profit by experience" (125)

	16. Response to Conflict or Frustrating Experiences
1939 Hulbert	Some "can not meet stress," tending to suicide or other means of escape (11) "extreme over-compensation" in some cases (11)
Pargen	"vast majority make good patients or convicts" (415) "lend themselves to routine and prove trustworthy, under disciplinary supervision." (415)
Wilson and Pescor	When frustrated, they fly into abnormal rages or become sullen and surly." (172)
1940 Karpman	"can't stand privation well" (206) "easily blow up when the situation becomes a bit stressful." (206)
Levine	"tend to solve their life conflicts by overt behavior, by putting their conflicts, or aspects of them, into action, by attempting a solution of their life problems by distorted behavior toward themselves or toward others, in short by 'acting out.'" (849)

APPENDIX D-1

Year and Author	16. Response to Conflict or Frustrating Experiences (cont'd.)
Noyes and Haydon	More prone than normal persons to develop psychoses, particularly situation psychoses (216)
1942 Maughs	"Suicidal gestures and the appearance of depression" when in trouble. (500)
1943 Silverman	"Anxiety is rarely manifest, and then only in response to situational difficulty (e.g., incarceration) which the psychopath has brought on himself." (19) "Tolerance to frustration or tedium is poor" (19)
1944 Lindner	Frequent frustration (4) Frustration leading to (a) quitting the scene of frustration, (b) aggressive behavior or (c) neurotic or psychotic behavior (4)
	17. Adjustment to Reality Principle
1940 Levine	Live in terms of "the pleasure principle" (849)
1941 Hall	"the immediate desire being all-important" (385)
1942 Geil	Fails "to think things through beforehand" (126)
Kaufman	"only aim is to immediately gratify his needs and wishes." (137) "appears to live purely by the pleasure principle." (137)
Maughs	"pleasure at any cost" (512)

APPENDIX D-1

Year and Author	17. Adjustment to Reality Principle (cont'd.)
Maughs (cont'd.)	"Laziness . . . except in the fruitless pursuit of pleasure." (713)
Szurek	"immediate gratification of whatever impulses happen to control them" (2)
Wooley	"show . . . a relative inability to forego a present satisfaction for a future gain" (926)
1944 Lindner	Predominance of behavior leading to immediate satisfaction (2)
	18. Nature and Extent of Life-goal
1938 Twitchell	Often "indifferent as to their own future penalties." (423)
1939 Pargen	"never with a definite objective." (414)
Wilson and Pescor	"Like rudderless ships with no port in view" (131)
1940 Karpman	"unable to project themselves into the future and foresee the consequences of their acts." (205) Immediate satisfactions "with no thought of consequences" (205)
Levine	They "live to a greater degree than is healthy in terms of short term values." (849)
1941 Caldwell	"living on the principle that pleasure is the chief goal in life" (172) "little thought for the future" (172)
Chornyak	"creatures of the present. The future is as nothing to them." (1332)

APPENDIX L-1

Year and Author	18. Nature and Extent of Life-goal (cont'd.)
Cleckley	Commits misdeeds at great risk of being discovered and "in the absence of any apparent goal at all." (240) "striking inability to follow any sort of life plan consistently" Without "any far goal at all." (255)
Menninger	"seem to live only for the moment, and that moment is filled with a grand show of intention contrary to the patient's deeper intentions." (154) "They feel that they have everything to gain and nothing to lose, right now; the future is a vague uncertainty." (154)
Sprague	"incapacity for delaying." (913)
1942	
Kaufman	"unable to proceed through life with any definite pattern of standardized activity." (129*) "lack of continuity of purpose." (129*) "only aim is to immediately gratify his needs and wishes." (137) "no ability to react on the basis of any but short-term goals." (137)
Mangun	"Lack of fixity of purpose" (117) "Tendency to discount the future heavily in terms of the present"
Maughs	No planning for the future. (706)
1943	
Silverman	"lack of any consistent life plan." (19)
1944	
Lindner	Inability to make determined progress toward a goal "unless it is a selfish one capable of immediate realization by a sharply accented spurt of activity" (?) Characteristically aimless (?)

APPENDIX D-1

Year and Author	19. Capacity for Sustained Activity in Any One Direction
1937	
Wholey	"instability in his work record." (57)
1939	
Mangun	"apparently incapable of sustained creative effort." (308) "seem incapable of reacting favorably to any environment for long" (309)
Pargen	"unable to apply himself for long at a given task" (414)
Wilson and Pescor	"drift hither and yon"
1941	
Caldwell	"Frequent change" (171) -- "most easily detected characteristic" (179) "inability to withstand tedium" (171)
Hall	"lack of perseverance" (385) "shifting occupational adjustment" (385)
Menninger	"passing as by a leap from one thing to another; marked by breaches of continuity or abrupt transitions or variations" (155)
Richards	"Inability to stick to any one activity for more than a few months at a time." (145)
1942	
Kaufman	"lack of tenacity of purpose" (129*)
1943	
Silverman	"Efforts are unsustained" (19) "interests are fragmentary" (19)
1944	
Lindner	A low "limen of satiety," with consequent boredom (4)

APPENDIX D-1

Year and Author	20. Degree of Dependability or Reliability
1939 Pargen	"can never be depended upon in matters of morals, logic, or ethics." (414)
1940 Karpman	"wholly unreliable" in statements or promises (204)
Noyes and Haydon	"unreliable" (213)
1941 Hall	"unreliability"
1942 Kaufman	"not to be depended upon" (129*)

	21. Attitude Toward and Relationship With Others
1939 Hulbert	"Can not get along with others" (14) "forever socially maladaptable." (14)
Mangun	"excessive in their demands" (308)
Pargen	"total lack of consideration for others" (414) "demanding everything, but giving nothing." (414)
1940 Karpman	"no consideration for the interests of others." (203) "heartless" (203) Always at "the receiving end" rather than at the giving end except when "under duress and pressure" (203) "do not and seemingly cannot develop those binding emotions and tender attachments which lie at the very basis of human evolution and our whole social structure." (203) "source of greatest tension" within the family (205)

APPENDIX D-1

Year and Author	21. Attitude Toward and Relationship With Others (cont'd.)
Karpman (cont'd.)	"unable to grasp the meaning and value of human life for others" (205-206)
Noyes and Haydon	"cannot adjust with others and fit harmoniously and effectively into the organized social environment." (212)
1941	
Caldwell	"dependence on others to avoid the consequences of misdeeds" (172) "defiant attitudes" (171)
Chornyak	"self-centeredness and absolute selfishness" in social relationships (1326) "behaves as if he had no regard whatever for the feelings and welfare of others." (1327)
Cleckley	An apparently absolute "incapacity for object-love" (241) "no sense of responsibility whatsoever to others." (239)
Hall	"incapability of real affection for others or of appreciation of their point of view, their rights or their property" (385) Appears to expect the environment to adapt itself to him (385) "suspiciousness and paranoid projection on others." (385)
Menninger	"puts up a front or facade for the benefit of the person he desires to impress or exploit" (154) "irritates, disappoints and distresses" everyone (154) "fraudulency and insincerity" (154) "seem incapable of any sustained loyalties to anyone." (154) "maintains no consistent fealty." (154)
1942	
Kaufman	"easily influenced" (129*) "will not conform himself to organized authority and he derives much satisfaction in cultivating dissatisfaction in

APPENDIX D-1

Year and Author	21. Attitude Toward and Relationship With Others (cont'd.)
Kaufman (cont'd.)	others." (129*) "past irresponsiveness to social demands" (129*)
Mangun	"Resentment of supervision" (118) "Possession of few desirable friends" (118)
Maughs	"the ever recurring impulse to live at the expense of others without making any return" (515) "a lack of affection for spouse and children without any feeling of responsibility for them." (516)
Reichard	Considers himself "right and everyone else wrong." (139)
Statistical Manual	"without consideration of others"
1943	
Silverman	"insincere, untrustworthy, irresponsible, sometimes overbearing and demanding and often outright hostile." (19) "Close interpersonal relationships are never developed" (19)
1944	
Lindner	"inability . . . to cherish class loyalties, and his continual struggle to change his class" (112)
	22. Acceptance of Responsibility
1937	
Wholey	"unwilling to assume any social responsibilities which he can avoid." (57)
1940	
Karpman	"no appreciation of the meaning of responsibility of any sort" (204)
1941	
Caldwell	"Lack of a sense of responsibility" (172)

APPENDIX D-1

Year and Author	22. Acceptance of Responsibility (cont'd.)
Hall	"irresponsibility" (385)
	23. Empathic Capacity
1938 Twitchell	"without any feeling for the sufferings of others" (423)
1940 Karpman	"wholly unable to 'feel' for and with others." (203)
Noyes and Haydon	"lack of sympathy for others." (213)
	24. Intellectual Aspects
1938 Twitchell	"ranges from low-normal to genius." (423)
1939 Henderson	"conform to a certain intellectual standard, sometimes high, sometimes approaching the realm of defect but yet not amounting to it" (18)
Hulbert	Variations from low to high (4)
Mangun	"high intelligence when measured by the usual psychometric tests" (314)
Pargen	"none of these people show a lowered I. Q. In fact, many of them are well above a normal quotient." (414)
1940 Karpman	"often of very high intelligence" (205) "unable to utilize 'intelligence' for genuine advantage to themselves or for socially useful purposes." (205)
Noyes and Haydon	Condition not due "to lack of intellectual capacity." (212)

APPENDIX D-1

Year and Author	24. Intellectual Aspects (cont'd.)
Noyes and Haydon (cont'd.)	"a misleading appearance of knowledge" (214)
1941	
Caldwell	"ability to realize consequences intellectually but not to evaluate them" (172)
Chornyak	"intellectual inefficiencies" (1328) On Stanford-Binet: "may be a high I. Q. but frequently there is a wide scatter due to a very low basal age." (1329)
Cleckley	"usually more clever than the average" (238) Non-deteriorating intellectual powers (238) Understanding of the arts is never "actual or sincere," though sometimes cleverly faked. (211)
Richards	Average or above, but a kind of "dumbness," by virtue of which he is often easily caught (145)
Sprague	"intellectual functions . . . dominated by his emotional stresses." (915)
1942	
Geil	"not in any way unusual from the standpoint of tested general intelligence." (122) "an unrefined, rigidly repressive, or constrictive intellectual control which does not 'control' when control is most needed." (123)
Kaufman	"not suffering from a congenital defect in the intellectual sphere" (129*) Generally "average or even above the average." (132)
Mangun	"Degree of involvement bears no relation to tested intelligence" (118)

APPENDIX D-1

Year and Author	24. Intellectual Aspects (cont'd.)
Maughs	When intelligence is sub-normal, psychopath functions at a "low level," losing "cleverness," "the polished grace and suave manner" (515)
Statistical Manual	"Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may be present."
Wooley	"of normal or near normal intelligence" (926)
1943	
Silverman	"Although sometimes there is an appearance of brilliance, thinking is superficial and at a plane far below that anticipated from the psychometric test level." (19)
1944	
Abrahamsen	May be of superior intelligence, but not necessarily so (107)
Lindner	"The intelligence of the psychopath can be described only adjectivally and in terms of the whole personality." (5) The kind of intelligence suitable for psychopathic behavior (5) "the amazing excess-cargo of uncoordinated and useless information" (6) Knowledge superficial and undigested (6)
1945	
Darling	"without intellectual impairment" (125)
	25. Sexual Components
1937	
Wholey	Account for "most of the perversities of sex" (58)

APPENDIX D-1

Year and Author	25. Sexual Components (cont'd.)
1938 Twitchell	Apparently includes the sexually precocious, inverts, and perverts (422)
1939 Henderson	The gamut of sex perversions (75 ff)
Hulbert	Polygamous (10-11) "unwilling to give sex satisfaction to . . . partner" (13)
1940 Karpman	Frequently "excessive heterosexuality, promiscuity, and a readier intrusion of paraphiliac trends . . . than is found in the normal" (204) Generally "endowed with a sex drive considerably above the average" (204) "entirely selfish, thoroughly narcissistic attitude toward the mate." (204) "extreme satisfaction in conquest" (204) "can be fine lovers" but "as a rule make poor husbands or wives, fathers and mothers." (204) "rather large homosexual component" (205)
Noyes and Haydon	Abnormalities in degree or in nature of impulse, including eroticism, frigidity, perversion, or inversion (215) "deviations of sex impulse" (212)
1941 Caldwell	"extreme erotism" (171) Homosexuality or other perversion (171) Mainly self-gratification (171)
Chornyak	"uncontrolled in their sexual activity." (1331) "participate in all forms of sexual activity." (1331)
Cleckley	Homosexuality and other perversions not characteristic, though they sometimes occur (252) Great promiscuity (from "lack of self-imposed restraint") but without great sex drive in the usual sense (253)

APPENDIX D-1

Year and Author	25. Sexual Components (cont'd.)
Cleckley (cont'd.)	"astonishing predelection for obscenity in sex-attitudes" (254) Apparently absolute "incapacity for object-love" (241) A certain lack of "mature erotic aims" (146)
Richards	"sexual aggressiveness" (145)
1942	
Kaufman	"many homosexuals" Includes "Most of the cases involving sexual delinquency" (131)
Mangun	"Tendency towards homosexuality and sex-perversion" (118) "Markedly delayed psychosexual maturity" (118)
Maughs	Sexual urges without "unity or direction." (501) "A woman becomes to them a mere object of gratification and one seems to do as well as the next." (516) "not only its utter lack of emotional tone but the mystery that surrounds it." (714)
Reichard	"sexual perversions." (144)
Statistical Manual	"sexual perversions" in some
Wooley	"sexual activity is almost invariably diffuse and diverse" (930) "sexual configuration of the individual is apt to be poorly integrated so that manual, oral, anal and genital activities are utilized, if not quite indifferently, nevertheless almost indiscriminately." (930)
1943	
Silverman	"Sexual relationships are promiscuous, inadequate (deficient) or perverse and are always lacking in real feeling tone for the object." (19)

APPENDIX D-1

Year and Author	25. Sexual Components (cont'd.)
1944 Abrahamsen	May show inadequacies in the psychosexual field which may result in deviations of the sexual drive (111)
Lindner	"neither lasting nor firmly set upon a community of desires." (6) "frequently homoerotic or perverse in some other sense" (6) "always self-aggrandizing." (6)
1945 Darling	Sexual deviations (125)
	26. Alcoholic and Drug Components
1937 Wholey	More teetotalers among 239 psychopaths in prison than among 200 non-psychopathic prisoners (57)
1941 Caldwell	"alcoholism or other addiction" (171)
Cleckley	Alcoholic indulgence may be prominent, but usually without "temporary psychoses directly due to alcohol" (247) "apparent lack of pleasure in drinking" (248) Goal appears to be "a state of stupefaction or of semi-stupefaction." (252)
1942 Kaufman	"alcoholics"
Maughs	Alcoholism likely to be prominent (708)
	27. Response to Generally Accepted Values of His Culture
1940 Karpman	"can simulate to perfection" "apparently positive social traits . . . when it

APPENDIX D-1

Year and Author	27. Response to Generally Accepted Values of His Culture (cont'd.)
Karpman (cont'd.)	suits their convenience" (207)
Noyes and Haydon	"frequently violates the sensibilities, amenities and conventions of society." (212)
1941	
Menninger	"breaks the rules as if he had a presumed impunity from the consequences which affect other people" (154)
Sprague	Shows "particular weaknesses and inabilities to measure up to the customary attitudes of his fellows." (916) "Apparently the cultural values are viewed from behind the psychopath's personal ramparts and are not taken into himself to become part of his own personality, there to cope with other traits in his own makeup." (916)
1942	
Kaufman	"unable to respond in an adult social manner to the demands of honesty, truthfulness, decency, and consideration of their fellow associates." (129*)
Reichard	"understands the rules by which civilized people live together but does not observe them" (139)
Szurek	"Unable . . . to acquire satisfactions in culturally acceptable ways." (2)
	28. Super-ego Development and Functioning
1939	
Henderson	"no capacity of true moral feeling, his impulses and desires are egoistic" (19)
Pargen	"utter disregard for decency and honesty." (414) "always out of step with society." (414)

APPENDIX D-1

Year and Author	28. Super-ego Development and Functioning (cont'd.)
Wilson and Pescor	"lack of ethical sense"
1940	
Karpman	"conscience-less, unprincipled sense-of-guilt-less individuals." (203)
Noyes and Haydon	"moral and ethical blunting" (213)
1941	
Caldwell	"orientation at the 'I' level" (172)
Chornyak	"little evidence of ego ideal or super-ego" (1328)
Cleckley	"total disregard for truth" and incapacity for understanding why others should value truth, yet expects his word to be accepted by others (239) "cheats and lies without any apparent compunction." (240)
Richards	Knows "the difference between right and wrong when he commits a crime, but he is so constituted that it is wholly impossible for him to act on this knowledge." (147)
1942	
Maughs	"it seems fantastic that a psychopath could have a conscience" (500) Repetition of acts that most people would be ashamed of (501)
Statistical Manual	"moral deficiency"
Szurek	"a defect in personality organization." -- more specifically, of the conscience (2) "deficient in moral sense." (2)
Reichard	Functions "too weakly." (139) "moral deficiency" (144)

APPENDIX D-1

Year and Author	28. Super-ego Development and Functioning (cont'd.)
1944 Lindner	Super-ego stunting (7)
1945 Darling	"super-ego deficiency" (125)
	29. Somatic Findings
1941 Chornyak	"cortical atrophy" revealed by pneumo-encephalographic studies (1332)
1942 Mangun	"Frequent history of neurotrophic disturbance -- enuresis, infantile asthma, and findings of subcynosis of of the extremities" (118)
1944 Lindner	A difference in the brain-wave patterning (10) Arrhythmic functioning of the great bodily systems (respiratory, circulatory, etc.) (10) "more sensitive organization of physiological preparatory devices for action" -- "more delicately-poised than his fellows" (11)
Silverman	"one essential factor in nearly all psychopathic personalities is a disturbed cortical function." (479)
	30. Interpretation of Difficulties
1939 Hulbert	"when things go wrong, accuse others and excuse themselves" (9)
Mangun	"Always prepared with an excuse for their chort-comings" (308) Place blame on others (308)

APPENDIX D-1

Year and Author	70. Interpretation of Difficulties (cont'd.)
Wilson and Pescor	"Their troubles are always projected upon their environment. To them it is always the 'irony of fate' or the malignant machinations of their fellowmen. Excuses to them are the same as reasons." (132)
1941	
Caldwell	"self-justification" (172) "the minimizing of the consequences of misdeeds" (172) "the projecting of blame to conditions or to other persons" (172)
Cleckley	"projects, blaming his troubles on others with the flimsiest of pretexts and subtle rationalization." (246) "never sincerely accepts any blame" or responsibility (239)
1942	
Mangun	"Unwillingness to accept responsibility for misdeeds" (117)
Maughs	Attempting to evade responsibility when in trouble (515) Projecting blame on others (515)
1943	
Silverman	"if the patient recognizes his difficulties at all, projection thinking is the commonest method of rationalizing them." (19)
	71. Insight
1941	
Cleckley	"lacks insight to a degree seldom if ever found in other mental disorder." (245) But sometimes "an excellent mimicry of insight." (246)

APPENDIX D-1

Year and Author	31. Insight (cont'd.)
Menninger	"some have very keen insight; some have insight but cover it up; others have no insight." (152)
1942 Mangun	"Lack of insight as to his inability to carry out his good intentions" (118)
1943 Silverman	"Insight is usually absent, although one is sometimes confronted with superficial verbal insight." (19)
1945 Darling	"lack of more than insight" (125)
	32. Important Negative Factors in Differential Diagnosis
1937 Bromberg and Thompson	"The concept of psychopathic personality is reserved for those whose exaggerations of emotion are not only beyond the individual's control but are unmodified by present methods of treatment."
1939 Henderson	Usually without shame (84) Rarely show remorse (77) Crimes may appear to be without motive (57)
Hulbert	Seems unaffected by his devastations (5)
Pargen	"none of these people show a lowered I. Q." (414)
Wilson and Pescor	"without inner emotional conflict" (130) "without loss of contact with reality." (130)

APPENDIX D-1

Year and Author	32. Important Negative Factors in Differential Diagnosis (cont'd.)
1940	
Karpman	"incapable of any sacrifice" (203) Incapable of both repression and sublimation (204) "seem never faced with emotional conflicts" (204)
Levine	"not necessarily psychotic" (849) "not neurotic in the usual sense of the word" -- or not necessarily so (849) "not necessarily feebleminded" (849)
1941	
Caldwell	"lack of remorse" -- or if it appears, of an insincere and transient nature (172)
Cleckley	Absence of generally accepted symptoms of psychosis and usually free from psychoneurotic symptoms (239) No successful or sincere attempt at suicide (252) "almost no sense of shame," humiliation, or regret (240)
1942	
Geil	"inner life . . . is devoid of the richness and fulness which tend to characterize the normally integrated personality." "inefficiency of personal and social adjustment" (124)
Kaufman	"relatively few" show physical stigmata (132)
Maughs	"rarely, if ever, attempts suicide" (511) "without any deep emotional ties." (697) "Lack of a sense of guilt" (713) "always in trouble" yet without apparent worry about it (695)
Statistical Manual	Not to include any of the psychoses "Cases of intellectual defect (feeblemindedness) are not to be included"
Wooley	"without evidence of organic damage to the central nervous system." (926)

APPENDIX D-1

Year and Author	32. Important Negative Factors in Differential Diagnosis (cont'd.)
1943	
Silverman	"absence of psychotic symptoms or a definite neurosis" (18) "Anxiety is rarely manifest, and then only in response to situational difficulty (e.g., incarceration) which the psychopath has brought on himself." (19)
1945	
Darling	Without psychosis or neurosis (125) "without intellectual impairment" (125)

	33. General Impression of Total Behavior
1939	
Pargen	"inefficient to a marked degree" (414) Behavior "completely unpredictable" (414)
Wilson and Pescor	"arrested development of the non-intellectual mental faculties" (130) "infantile reactions to adult situations" (130) "simply grown-up babies." (132)
1940	
Levine	"not normal . . . in the sense of maturity, of good health and adjustment" (849)
Noyes and Haydon	"certain variances, distortions and discords of personality which lie in the wide zone between mental health and mental disease." (212)
1941	
Chornyak	"pretty much stimulus-response organisms." (1332) "self-thwarting" acts (1330-1331)
Cleckley	"seems to go out of his way to make a failure of life." (255)
Sprague	"tendency to make incomplete or faulty synthesis." (914)

APPENDIX D-1

Year and Author	33. General Impression of Total Behavior (cont'd.)
Sprague (cont'd.)	Deals "with part pictures rather than with the total picture of his situation." (914) "Disvaluation of reality" (913) (as contrasted with denial of reality)
1942 Kaufman	"a life pattern of deviant behavior" (132)
1943 Silverman	"longitudinal review of his life reveals behavior which is reckless, impulsive, unrepressed and often bizarre and pointless." (19)
1944 Abrahamsen	"a form of chronic self-destruction." (107)

APPENDIX D-2

ETIOLOGY IN CURRENT LITERATURE

Year and Author	
1935 Selling	"inherently defective." (153)
1937 Wholey	Social conflict suggested because psychopaths are found more likely than non-psychopaths to have one or both parents of foreign birth (57) "little of importance in environmental factors" except "in activating any existing psychopathic trend." (58)
1938 Twitchell	For most -- "hereditarily tainted" (423)
1939 Henderson	Behavior may be compensation for feelings of inferiority (63)
Hulbert	"born with and not acquired" (3)
Mangun	"basically a biologic problem" (310)
Wilson and Pescor	"a functional hereditary defect partially modified by environmental conditions"
1940 Karpman	"any behavior . . . that is a result of or flows out of (unconscious) psychogenic difficulties belongs to neuroses or psychoses, and not to psychopathies." (200) Is "what he is because he has always been like that, it being quite impossible to trace this egoism or its development to any specific conditionings." (206)
Noyes and Haydon	"the product of constitutional, psychological and social factors" (215)
1941 Caldwell	"Either a neuropathic family history or unusual family associations were present in 27 of the 31 cases." (178)

APPENDIX D-2

Year and Author	
Caldwell (cont'd.)	Over-attachment to mother most prominent feature in the "unusual family associations."
Chornyak	"damage to the most recently acquired areas in the cerebrum." (1327) "cortical atrophy" revealed by pneumoencephalographic studies (1332) Cerebral damage sustained "during the normal egocentric period of personality maturation." (1337) Perhaps anoxemia at this time, resulting in sudden change of personality (1338) Perhaps also head trauma in early childhood (1338)
Cleckley	"not a lack of purpose so much as a negative purpose." (269) "manifestations of what has been called the will to fail" -- "a kind of protracted and elaborate social and spiritual suicide" (271) "the final result of conflict unsatisfactorily resolved, or unsatisfactorily dealt with by compensation, sublimation, or other mechanism of adjustment." (277) Probably began "to react faultily" early in life (274) "a more inscrutable and complicated disorder than even schizophrenia." (280) In addition to psychogenic factors, must consider also "the so-called constitutional factors, the possibility of some inherent or inborn defect." (281)
Menninger	"these individuals are nearly overwhelmed by their hate and aggressive impulses and control them only by a continuous pretense which fools even themselves." (154)
Richards	"considered to be hereditary." (144)
Sprague	"There has not been reported any structural pathology which would offer somatic or neuropathological foundation for psychopathy." (916)

APPENDIX D-2

Year and Author	
Sprague (cont'd.)	"a certain fixation or limitation in psychic development." "an inner primacy of wish-phantasy-urges is the dominant factor in the psychopathic personality." (920)
1942	
Geil	"much evidence . . . to indicate a systematized anxiety with a predominance of compulsive traits." (126) Suggests "a personality structure similar in many respects to that found in the psychoneuroses." (126)
Mangun	"Evidence of poor heredity" in some cases (118) "exaggeration of emotional imbalance normally present during youth and adolescence" (118)
Maughs	" . . . the pattern of psychopathy is the same in all and bears no relation to intelligence or social background and environment. These latter may influence the course of the psychopathic individual, but they never change inherent personality. They may help disguise his broken life and make his going somewhat easier, but they are in no sense causative factors." (516)
Reichard	A cortical basis for "an inadequate amount of control of the lower more primitive levels by the higher ones" (144)
Statistical Manual	"apparently on the basis of constitutional defect"
Szurek	"no greater mystery than other syndromes in psychopathology. Almost literally, in no instance in which adequate psychiatric therapeutic study of <u>both</u> parent and child has been possible has it been difficult to obtain sufficient evidence to reconstruct the chief dynamics of the situation. Regularly the more important parent -- usually the mother, although

APPENDIX D-2

Year and Author	
Szurek (cont'd.)	the father is always in some way involved -- has been seen unconsciously to encourage the amoral or anti-social behavior of the child." (5)
Wittels	"Neurotics live through in their dreams what the psychopath actually carries out." (213) "confuses opposites" -- "love and hate (murder), mine and yours (theft), true and false (lie), reality and imagination (imposter)" (210-211) "a particular inability to understand vital contrasts." (211) "biological polarity not definitely settled, the polarity of male and female." (211) Often loss of one or both parents between ages of 4 and 7. (211) "greatest damage lies in traumatic experiences those early days." (212) "personality structures of psychopaths have their origin in the Oedipus conflict and its derivatives" (212) "fixation point" in the "so-called phallic phase" (212)
Wooley	"the defect appears to be in the training of the child who, because of parental attitudes, is trained rather in skills of aggression and indulgence of impulse rather than in the controls which society usually demands in its members." (928)
1943	
Silverman	In a study of 75 criminal psychopaths, "only 15, or 20 per cent, had tracings classifiable as normal." (25) The EEG tracings of "40, or 53.4 per cent, were definitely abnormal." (25) "80 per cent of the patients had abnormal or borderline abnormal brain rhythms and were suffering from cerebral dysfunction, whether it was inherent, congenital or acquired in later life." (28)

APPENDIX D-2

Year and Author	
Silverman (cont'd.)	An additional "10 per cent with normal tracings, but with signs suggestive of organic disease of the brain" (28) "a brain which is malfunctioning, and which has been malfunctioning since early childhood." (28) Results "from inborn or early acquired cerebral dysfunction and disturbed parent-child relationships." (31)
1944	
Abrahamsen	"must involve himself in behavior disorders in order to be punished." (108)
Lindner	"suspicion of malfunctioning in the higher cortical regions" (10) A difference in the brain-wave patterning (10) Suggesting a similarity to some of the organic brain diseases (10) Arrhythmic functioning of the great bodily systems (respiratory, circulatory, etc.) (10) "more sensitive organization of physiological preparatory devices for action" -- "more delicately-poised than his fellows" (11) The possibility of behavior of protest, aggression and hostility being "merely homeostatic adjustments operating to restore a disturbed organism balance." (11) No passage "beyond the pre-genital level of sexual development to the stage of object-love" (6) "There seems to be little doubt that the special features of psychopathic behavior derive from a profound hatred of the father, analytically determined by way of the inadequate resolution of the Oedipus conflict and strengthened through fears of castration." (7) "there is no other way in which he can be described except by reference to the social order in which he happens to exist . . . . psychopathic behavior is relative to the culture in which it

APPENDIX D-2

Year and Author	
Lindner (cont'd.)	flourishes and can be measured by no other rule than that of the prevailing ethic and morality." (1)
Silverman	"one essential factor in nearly all psychopathic personalities is a disturbed cortical function." (539) EEG and response to sodium dilantin "suggestive of a relationship between epilepsy and psychopathy" (445) "determined largely by psychological traumata." (446)
1945	
Darling	"inherited predisposition, or by acquired personality deviation due to psychic or somatic factors or both, which in turn, cause super-ego deficiency" (125)

APPENDIX D-3

PROGNOSIS IN CURRENT LITERATURE

Year and Author	
1939 Healy and Bronner	This volume is a study of the after careers of 400 cases treated between early 1931 and January 1934. Period of time elapsed between beginning of treatment and investigation of after careers was from five to eight years. (13) Of the 400, 323 (81%) were regarded as having favorable careers, while 77 (19%) had unfavorable careers. The most favorable outcome is reported for those classified as "personality and behavior problems," with favorable careers resulting for 189 (91%) and unfavorable careers for 18 (9%). Both the "non-court delinquents" (137) and the "court delinquents" (56) showed 70% favorable careers and 30% unfavorable careers. (25) In marked contrast to the total picture stands the record for those diagnosed as "definitely abnormal personality," including "psychopathic personality," "constitutional inferior personality," "brain damage cases," and "unclassified abnormal personality." Closely allied is another category, "probably abnormal personality." The authors summarize the results: "Only 7 of the 44 definitely and probably abnormal personalities have shown favorable careers of any degree. The remaining 37 cases account for 48% of those with unfavorable careers. "Of these 7 whose careers are considered relatively favorable, 4 are constitutionally inferior personalities who are living under conditions which do not demand much of them. Another suffered from brain damage that nature over the years has gradually corrected; one girl has markedly stabilized with maturity, marriage and responsibility for her children; and one through prolonged foster home placing and much other social

APPENDIX D-3

Year and Author	
Healy and Bronner (cont'd.)	and psychiatric treatment has shown measurable improvement. "The abnormal personalities came to the clinic for an average of ten psychiatric interviews (range 2 to 20) while their parents averaged nine consultations. Many received special medical and dental treatment, 4 had thoroughgoing endocrine studies and treatment, 22 were placed in foster homes, often for long periods, and many educational adjustments were made." (49) Of the fourteen diagnosed psychopathic personality, only one had a favorable after career. In contrast are those diagnosed "extremely neurotic"(also fourteen cases) with twelve favorable after careers. (35)
Hulbert	Condition is "irreversible, i.e., incurable or irremediable" (3) "modification is tedious and slight if possible at all." (3)
Mangun	Some "reform" later in life (310) "long range prognosis . . . much more favorable than is generally believed." (314) "after a long period learn from experience" (314)
Pargen	"lend themselves to routine and prove trustworthy, under disciplinary supervision." (415)
1940	
Karpman	"resistant to any attempt made to improve them." (203)
1941	
Chornyak	Very poor, if not altogether hopeless (1340) Compares it with "inoperable carcinoma" (1340)

APPENDIX D-3

Year and Author	
Cleckley	"no punishment will make the psychopath change his ways." (241) "much more disheartening than schizophrenia" (229) Has found "all true examples of semantic dementia to be very little influenced by therapeutic efforts . . . . for the ordinary psychiatrist at least, all efforts at treatment along analytical or re-educational lines will be blocked by an unmodifiable lack of insight, a lack of capacity for a real transference, and an almost complete lack of any real desire to get well." (285)
Hall	"peculiarly unamenable to discipline." (385)
1942	
Mangun	Believes it possible to change attitude through "therapeutic seclusion" (121)
Maughs	"the commonly accepted belief is that the psychopath is untreatable." (712-713)
Wittels	"not as yet very efficient in the treatment and 'cure'" (215)
Wooley	"under proper training conditions he can learn" (934)
1944	
Abrahamsen	Thinks that these offenders will "have a chance to mature and to adjust socially when they reach about forty-five." (198)
1945 (February)	
Darling	"of lifelong duration in almost all cases." (125)
1945 (March)	
Darling	Outlook is changed "from one of pessimism to one of optimism." (250)

APPENDIX D-4

THERAPY IN CURRENT LITERATURE

Year and Author	
1935 Selling	For juveniles: "Institutionalization, with very strict training. Strict training at home, under supervision. Removal of possible conflicts with parents by treatment of parents at a clinic." (154) For adults: Treatment in a "psychiatric clinic, particularly one where psychoanalysis is used." (139) "hospitalization" (preferably) or "incarceration for a long-time period" (139)
1938 Twitchell	"stern discipline from very early years." (424)
1939 Healy and Bronner	These authors deal with the "abnormal personalities" as a group in the matter of suggested therapy. This category includes the psychopathic personalities. The authors confess themselves "interested in discovering what, if anything, might be accomplished through intensive treatment for abnormal personalities." (49) The poor prognosis for this group follows from the results of this intensive treatment. "They certainly require long-time segregation in properly adapted colonies with experimental methods of re-educative therapy." (49) They do not believe intensive individualized treatment (such as they gave) to be justified. (49) "Sometimes it is essential for diagnosis that foster home treatment be tried for an experimental period in order to observe the individual's behavior in a new and favorable environment. But once the diagnosis is established, it should be recognized that neither clinic

APPENDIX D-4

Year and Author	
Healy and Bronner (cont'd.)	nor child placing agency can achieve enough modifications of abnormal personalities -- in the present state of our knowledge -- to warrant great expenditure." (49-50)
Henderson	"no adequate provision of a preventive or curative nature." (18) It is significant that the term which Henderson uses in this connection is social rehabilitation (127 ff) Does not expect much help from psychoanalytic approach (135 f) Need for organization "which has to do with the education and synthesis of the individual" (138) "The more carefully we study our case material, the more accurately we assess the potentialities, the stronger becomes the conviction that, by the use of psychobiological principles, we can contribute greatly to the process of readjustment. We aim at giving the patient a sense of security, a feeling of being understood, and enough encouragement to enable him to utilize his assets to the best advantage." (158) "(1) a medical service which reaches every member of the community; (2) a psychobiology which is generally applicable; (3) an educational system correlated with the development of spontaniety and working in harmony with preventive medicine." (163)
Hulbert	"remove pain or burden or menace from the community by removing him." (21)
Mangun	"detention within an institution . . . until such degree of psychological maturation is reached that will enable them to be useful members of society." (314) "a large measure of time and patience" (314)

APPENDIX D-4

Year and Author	
Pargen	"record finger prints of all citizens" (415) "Available to every court there should be a psychiatrist to examine each individual convicted of an offense no matter how minor. If that person is found to be of a psychopathic personality, he should be so labeled and indexed, ever afterward to be under the supervision of probation." (415) "modified detention camp . . . for the employment of prison-released psychopaths" (416)
1940 Schilder	"The psychopath has no manifest conflict between his super ego and his ego. He has reached some sort of equilibrium which is acceptable to him from the point of view of his personality. The problem of psychotherapy will therefore first be to make the individual feel sick and then to cure his illness. However, individual psychotherapy in these cases may often be in vain, and one will have to change the environment so that the environment fits the situation. The non-criminal psychopath very often can exist only in an environment which is either made easy or strictly regulated. He may need a helping hand throughout his lifetime whether he is analyzed or not analyzed. Criminal psychopaths have not only to deal with their psychopathy but also with their crime and the penal institution will be very often an environment which drives the psychopath deeper into his conflicts."
1941 Chornyak	Attempts at treatment seem not to justify the expenditure. (1340)
Cleckley	"special institutions where psychiatric study could be concentrated on them as a particular problem" (286) with

APPENDIX D-4

Year and Author	
Cleckley (cont'd.)	experimental parole and cautious release for those showing "any promise of being able to adjust to life in the community." (290) Supplement psychotherapy and occupational therapy with "some procedure designed to cause an extensive profound alteration in the psychobiologic functioning of the patient" (290) Shock therapy may prove to be of value (291) "a profound reorientation of some sort is necessary." (293)
Richards	"unmodifiable human material." (147) "Needless to say when one suspects a psychopathic personality in young childhood, no stone should be left unturned to give the boy or girl the best possible chance in habit training. If anything can help them to even a small measure of stability it must come through long periods of patient, consistent, day-by-day training procedures." (151)
1942	
Banay and Davidoff	In one case (male, 52 yrs. of age) after lobotomy -- "Within three weeks after the operation, the compulsive drive of his obsessions ceased . . . . The patient gained insight and evidenced a newly developed ethical sense. From a social viewpoint he could be regarded as recovered." (65)
Chiles	"demonstrotherapy": "an attempt to reorient the total personality with the corrected deficiency in an environment where the forces of opposition are at a minimum, and without the individual feeling too strongly or too consciously, what is being done. Once this stage of correctional and demonstrotherapy is passed, usual psychotherapeutic procedures are relatively easy and successful.

APPENDIX D-4

Year and Author	
Chiles (cont'd.)	"Attempts at any kind of treatment of psychopathic delinquents who have reached their normal maturation point in all phases except the lagging component have been unfavorable, particularly so if the developmental lag is great. Delinquents who have not reached the normal maturation point react to therapy in a favorable fashion, and are able to absorb by their developing normal components. It would follow logically, that the sooner correctional procedures are applied to the lagging components, the better the prognosis." (102)
Mangun	"involves a large measure of time and patience." (119) "therapeutic seclusion and re-education" by the psychiatrist (119-122) (not to be confused with punitive isolation) Individual treatment only. Believed that this treatment accelerates emotional maturation.
Reichard	"some substance may be developed which will correct this disfunction." (145) "especially among children" -- "improved habit patterns along the line of the conditioned reflex technique." (146)
Wittels	Psychoanalysis is of "some help" (215) Believes more hope lies in prevention -- "this depends on education, primarily of the pre-school child." (215) "problem centers around the formation of the superego" (215) "what was not accomplished in childhood when the developmental conditions were much more favorable must be brought about by treatment at a much later date -- a complex and difficult task which cannot be successful without that almost magic component called love or grace or, more soberly and scientifically, transference." (216)

APPENDIX D-4

Year and Author	
Tooley	"a consistent disciplinary regimen in which the impulsive behavior would constantly be deprived of success and in which the natural consequences of such behavior would be allowed to impinge upon the individual in every case." (931) "a refusal to let the psychopath exploit those who surround him while at the same time he is not rejected." (931)
1944	
Abrahamsen	Thinks "that psychoanalysis should be of great help." (197) Institutional training program aimed at "repairing their character defects." (197) "a continued disciplined regime in a friendly way." (197)
Lindner	Modern penological practices entirely inadequate. The use of hypnoanalysis for the purpose of investigating and treating the psychogenic disorders which are believed to contain the secret to psychopathic behavior. Correction of the cultural factors.
Silverman	Suggests as "The first consideration . . . the use of special diagnostic procedures for the detection of cerebral lesions." (445) Concerning sodium dilantin -- "It is gratifying to see that the drug apparently helps some psychopaths." (444) Psycho-therapy (446)
1945 (March)	
Darling	Presents three cases of diagnosed psychopathic personality in which electroshock treatment was tried. "Even two cases of improvement change the outlook, in my eyes at least, from one of pessimism to one of optimism." (250)

APPENDIX E

RESULTS OBTAINED FROM THE QUESTIONNAIRE-SURVEY

This appendix is arranged in such a way as to provide the optimum amount of information in regard to the replies from the questionnaires. Each of the questionnaires has been numbered, and these numbers appear in connection with the answers to each of the questions on the following pages. Thus all answers marked, for example, "1" under the classification "psychiatrists in state mental hospitals" came from the same questionnaire.

Generally speaking, the questionnaires were answered by the persons to whom they were sent, or at least by someone occupying a closely related position. The following list, by categories, calls attention to the exceptions:

Psychiatrists in state mental hospitals -- no exceptions.

Psychiatrists in correctional institutions -- questionnaires numbered 22, 23, 24, 25, 26, and 27 were referred to these psychiatrists by the superintendents of their respective institutions.

Psychologists in correctional institutions -- all eight of these were referred to the psychologists by the superintendents of their respective institutions.

Superintendents of juvenile correctional institu-

tions -- answered by superintendent except: #17 answered by administrative assistant; #26 answered by chief clerk.

Superintendents of adult correctional institutions -- answered by superintendent except #16, which was answered by the general accountant.

State departments of welfare -- answered by director or head of some special division (e.g., Division of Child Welfare or Consultant on Foster Care) except as follows: #4 answered by the executive psychologist, State Bureau of Juvenile Research; #8 answered by the director of the Division of Mental Hygiene, which in this instance comes under the welfare department; #12 answered by the chairman of the Juvenile Institute Commission; #21 answered by a state psychiatrist; #33 answered by the psychiatrist at an institute for juvenile research.

Independent juvenile courts -- answered by the judge except as follows: #1 answered by the director of a court; #3 answered by the administrative assistant to the court; #6, #13, #14, and #15 answered by chief probation officers; #10 answered by the director of the court's psychiatric clinic; #16 answered by the register of the juvenile court.

Combined juvenile courts -- answered by the judge except #4, #8, and #14, which were answered by probation officers.

Circuit court level -- answered by the judge except

#32, which was answered by the solicitor general.

Magistrate court level -- answered by the judge.

APPENDIX E-1

EXTENT OF THE USE OF THE PSYCHOPATHIC CONCEPT

Question: In your work, do you use the classification of "psychopath" or some similar term?
a. Yes
b. No
If there is some other similar term which you use instead of "psychopath," please give that term here . . . .

Answers from State Departments of Welfare

"Yes" -- #2,4,5,7,8,10,12,13,15,18,33
"No" -- #3,6,9,11,14,16,17,20,21,22,23,25,29
Other answers -- "Not often" (#1)
Not answering this question -- #19,24,26,27,28,30,31,32
Similar term used -- Psychopathic personality (#4). Psychoneurotic (#7). Sometimes use "individuated boy" instead of psychopath (#12). Asocial delinquent (#33).
Comments or qualifications:
#1 -- "Because of lack of diagnostic facilities -- also attempt to avoid its use."
#7 -- Despite the use of the term "psychoneurotic" in this connection, a letter accompanying this questionnaire indicates a definite knowledge of the psychopath as distinct from the psychoneurotic.
#10 -- "Occasionally"

Answers from Independent Juvenile Courts

"Yes" -- #1,3,4,5,6,10,11,12,15
"No" -- #2,7,9,14,16
Other answers -- "Rarely used" (#8)
Not answering this question -- #13
Similar term used -- Psychopathic personality (#10 & 15). C.P.I.-E.I. (#11). More individually descriptive terms (#16).
Comments or qualifications:
#12 -- "Sometimes"

Answers from Combined Juvenile Courts

"Yes" -- #2,5,6,7,8,9,14,16
"No" -- #3,4,10,11,12,13
Not answering this question -- #1,15
Similar term used -- Character disorder (#14). Mental case (#16).

APPENDIX E-1

Answers from Circuit Court Level

"Yes" -- #1, 19, 21, 27, 31, 37, 43, 44
"No" -- #3, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 20, 22, 23, 24, 25, 26, 28, 29, 30, 33, 35, 38, 44
Not answering this question -- #2, 4, 6, 12, 32, 34, 36, 39, 40, 41, 42
Similar term used -- Alcoholic or insane (#11). Insane person or mental defective (#14). Mental incompetent (#37). Mentally defective (#43). Sane or insane (#44).
Comments or qualifications:
#22 -- "Except under probation"

Answers from Magistrate Court Level

"Yes" -- #1, 4, 6, 7, 8, 10, 17
"No" -- #2, 3, 9, 12, 13, 15, 16, 18
Not answering this question -- #5, 11, 14, 19

APPENDIX E-2

INCIDENCE OF THE PSYCHOPATHIC OFFENDER

Question: What percentage of cases within your institution in the year 1945 was diagnosed as psychopathic without psychosis? _____%
What percentage diagnosed as psychopathic with psychosis? _____%
(If figures are not available for 1945, please list in above spaces the percentage for the latest available year and state year here.____)

N.B. The wording of the above question was varied somewhat for the other groups to which the questionnaire was sent. For exact phraseology in each instance, see complete questionnaires in Appendix B.

Answers from Psychiatrists in State Mental Hospitals

Questionnaire #	% Without Psychosis	% With Psychosis	Total	Year
1	0.91%	0.53%	1.44%	1943-44
2	0.27%	0.27%	0.54%	1945
3	0%	0.6%	0.6%	1945
4	2.98%	2.66%	13.78%	1945
5	2.3%	1.2%	3.5%	1945
6	0.894%	0.596%	1.49%	1945
7	0.015%	0.005%	0.020%	1945
8	1%	0%	1%	1945
9	6.9%	1.6%	8.5%	1945
10	2%	1%	3%	1945
13	11 cases	5 cases	16 cases	1945
14	0.5%	8.5%	9%	1945
15	0%	20%	20%	1945
16	0%	60%	60%	1945
17	1%	0.5%	1.5%	1945
18	0.5%	2%	2.5%	1945
19	8%	8%	16%	1944-45
20	0.45%	1.35%	1.80%	1940
21	2.77%	0%	2.77%	1945
22	0.2%	0%	0.2%	1945
23	Approximately 5 cases	Approximately 5 cases	Approximately 10 cases	1945
24	1.56%	0.82%	2.38%	5-1-46
25	About 0.6%	About 0.4%	About 1%	1945
26	0.5%	0.3%	0.8%	1945
27	1.2%	1.2%	2.4%	1945
28	0.2%	1%	1.2%	1945
30	5.3%	7.4%	12.7%	1945
31	About 5%	About 5%	About 10%	1945

APPENDIX E-2

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Questionnaire #	% Without Psychosis	% With Psychosis	Total	Year
32	0.6%	1.2%	1.8%	1945
33	1.3%	1%	2.3%	1945
34	2%	0%	2%	1944-45
35	0.5%	1%	1.5%	1943
36	0.2%	0.047%	0.247%	1945
38	0.004%	1%	1.004%	1945
40	0.5%	1%	1.5%	1945
42	0.0053%	0.0088%	0.0141%	1945
44	0%	2%	2%	1945
45	0.05%	0.78%	0.83%	1945
46	0%	0.9%	0.9%	1944
47	0.7%	0.2%	0.9%	1945
49			1.5%	1944
50	0%	0%	0%	1945
51	0%	1%	1%	1945
52	0.018%	0.0013%	0.0193%	1945
53	2.961%	0.455%	3.416%	1945
54	0%	0.69%	0.69%	1945
55	0.006%	0.003%	0.009%	1945
57	0.5%	0%	0.5%	1944-45
58	0.5%	2%	2.5%	1945
59	0.5%	0%	0.5%	1945
60	0.8%	3.6%	4.4%	1945
61	0%	0%	0%	1945
62	2%	2.5%	4.5%	1945
63	3.03%	1.52%	4.55%	1945
64	0.5%	1%	1.5%	1945
65	0.07%	1.23%	1.3%	1945
66	0.0032%	0.012%	0.0152%	1945
67	0.468%	0.9%	1.368%	1945
70	0.01%	0.005%	0.015%	1945
71	2%	0.5%	2.5%	1945
73	0.007%	0.003%	0.01%	1945
74	1.48%	0.05%	1.53%	1945
75	100%	0%	100%	1945
76	0.17%	0.5%	0.67%	1945
77	0%	0.8%	0.8%	1945
78	1.6%	0.5%	2.1%	1945
79	2%	5%	7%	1945
80	Less than 0.5%	Less than 0.5%	Less than 1%	1945
81	1%	1%	2%	1945
82	No figures available			
83	0.5%	1%	1.5%	1945

APPENDIX E-2

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Questionnaire #	% Without Psychosis	% With Psychosis	Total	Year
84	0.65%	1.09%	1.74%	1945
85	2%	1%	3%	1944-45
86	0.016%	0.013%	0.029%	1945
87	No data			
92	.2585%	.9297%	1.1882%	1945
93	1%	.002%	1.002%	1945
94	5.2%	.86%	6.06%	1945
95	3.73%	1.11%	4.84%	1945-46

Not answering this question -- #11, 12, 29, 37, 39, 41, 43, 48, 56, 68, 69, 72, 88, 89, 90, 91

Comments or qualifications:

#1 -- "20% in criminal insane department, mostly without psychosis"

#4 -- "Psychopaths with other mental disorders, 8.14%"

Answers from Psychiatrists in Correctional Institutions

Questionnaire #	% Psychopathic	Year
1	Approximately 2%	2000 consecutive admissions
2	About 10%	1945
3	About 15%	1945
6	20%	1945
7	12%	1945
9	15%	1945
10	1%	1945
11	5%	1945
12	2%	1945
13	25% (estimated)	1945
15	0%	1945
23	40%	1945
24	8%	1945
25	20% (estimated)	1945
27	10%	1945
28	6%	1945
29	10% (estimated)	1945
30	At least 35%	1945

Not answering this question -- #8, 14, 16, 17, 18, 19, 20, 21, 22

Stating that they don't know or that figures are not available -- #4, 5, 26

APPENDIX E-2

Answers from Psychologists in Correctional Institutions

Questionnaire #	% Psychopathic	Year
1	3.3% (estimate)	1945
2	14.2%	1945
3	3-4%	1945
8	About 5%	1944-45

Not answering this question -- #5,6,7
Stating that statistics are not available -- #4

Answers from Superintendents of Juvenile Correctional Institutions

7	2.6%	1945
8	1%	1945
11	6%	1944
12	0.07%	1945
13	10% (estimate)	1945
14	25%	1945
15	3%	1945
16	Not more than 3%	1945
17	About 5%	1945
18	10%	1945
21	0%	1945
22	6%	1944
26	0%	1945
32	0%	1945
34	11%	1945
35	0%	1945
37	3%	1945-46

Not answering this question -- #1, 2, 4, 5, 19, 23, 24, 25, 28, 29, 30, 33
Stating that statistics are inadequate -- #3, 6, 9, 10, 31, 36
Other answers -- "Inadequate personnel for diagnosis" (#20). "No psychiatric service" (#27). "No official record, but probably 10 girls in past 5 yrs." (#38)

APPENDIX E-2

Answers from Superintendents of Adult Correctional Institutions

Questionnaire #	% Psychopathic	Year
1	7%	1944
2	10%	1945
3	2%	1945
4	20%	1945
5	About 2.7%	1945
6	0%	1945
7	3%	1945
10	About 10%	
11	52%	1945
13	8%	1945
15	19%	1944-45
17	6.4% of those studied	1945
21	0%	1945
23	2%	1946
27	27.6%	1945

Not answering this question -- #9, 18, 19, 20, 25, 26
Stating that % is undetermined or unknown, that figures are not available, or that no diagnosis is made -- #8, 12, 14, 16, 24
Other answers -- "Do not accept any" (#22)

Answers from State Departments of Welfare

4	4.1%	1929-38
12	Approximately 15-20%	1945
21	0%	
33	24%	

Not answering this question -- #15, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32
Stating that this classification is not used -- #1, 3, 6, 7, 9, 11, 14, 16, 17
Stating that % is unknown or not computed or that figures are not available -- #2, 5, 8, 10, 13, 18

Answers from Independent Juvenile Courts

4	0%	1945
6	Two juveniles so diagnosed in past four yrs.	

APPENDIX E-2

Answers from Independent Juvenile Courts (cont'd.)

Questionnaire #	% Psychopathic	Year
7	About 1%	1945
10	8%	1945
11	Approximately 25%	1945
12	About 0.33%	1945

Not answering this question -- #3, 5, 13, 14
Stating that classification is rarely, or never, used -- #2, 8
Stating that they don't know or figures not available -- #1, 15, 16
Other answers -- "No psychopaths in the 9½ yrs. this court has been in operation" (#9)

Answers from Combined Juvenile Courts

2	10%	1945
5	50%	1945-46
7	2-3%	1945
8	0%	1945
9	10%	1945
16	2%	1945

Not answering this question -- #6, 14, 15
Stating that this classification is not used -- #3, 4, 10, 11, 12, 13
Other answers -- "No experience" (#1)

Answers from Circuit Court Level

1	About 1%	1945
6	2%	
10	About 15%	1945
22	Probably 5%	
27	0%	1945
31	0%	1945
37	0%	1945
38	0%	1945
43	1 case out of 880	
44	5%	

Not answering this question -- #2, 12, 13, 17, 19, 39, 40, 41, 42

APPENDIX E-2

Answers from Circuit Court Level (cont'd.)

Questionnaire #	% Psychopathic	Year

Stating that this classification is not used -- #3, 5, 7, 8, 9, 11, 14, 15, 16, 18, 20, 23, 24, 25, 26, 28, 29, 30, 32, 33, 34, 35, 36

Stating data inadequate or unavailable -- #4, 21

Answers from Magistrate Court Level

1	Not over 1%	1945
4	1 case	
6	0%	1945
10	1%	1945
17	0%	1945

Not answering this question -- #5, 7, 8, 14, 15, 16, 18, 19

Stating that this classification is not used -- #2, 9, 12, 13

Other answers -- "I have nothing like this in my office" (#3). "We have nothing of this nature" (#11)

APPENDIX E-3

PERSON OR AGENCY HAVING RESPONSIBILITY FOR DIAGNOSING THE PSYCHOPATHIC OFFENDER OUTSIDE OF STATE MENTAL HOSPITALS AND CORRECTIONAL INSTITUTIONS

Question: After a case has been brought to the attention of the authorities, what person or agency has the responsibility of detecting and diagnosing the psychopath?

Answers from State Departments of Welfare

Questionnaire #	Person or Agency Having Responsibility
2	State Dept. of Public Welfare is responsible for studying the problems and needs of all committed children, and in this process uses clinical facilities within the Dept. and also the public and private facilities available elsewhere in the state.
4	State Bureau of Juvenile Research or local mental hygiene clinic or center.
5	County welfare boards.
7	Responsibility for recognizing psychopath rests mainly upon county welfare dept. and for probation officer; actual diagnosis made only by State Psychopathic Hospital or private psychiatrist.
8	State Dept. of Public Welfare to a certain extent.
10	Courts, unless delegated to an agency.
12	State or county clinic; psychological clinic after commitment.
13	Child Welfare Division of Dept. of Social Security may arrange for psychiatric studies -- if cases are referred to this dept. for case work service.
15	Public Welfare Dept.
18	The child may be referred to a child welfare unit or probation office, or the case may have gone into court and then referred to a clinic; but clinical services are so scarce that this is done on a negligible basis.
22	No one.
23	State social security commission, probation officers, probation and parole board.
33	Diagnostic clinic

Not answering this question -- #1, 3, 6, 9, 11, 14, 16, 17, 19, 20, 21, 24, 25, 26, 27, 28, 29, 30, 31, 32

APPENDIX 5-3

Answers from Independent Juvenile Courts

Questionnaire #	Person or Agency Having Responsibility
1	Psychiatrist
3	Juvenile court, Psychiatric Clinic, or private psychiatrist.
4	Hospital or coroner.
6	If a mental test made by the resident psychologist indicates psychosis, the child is taken to the psychiatric hospital for examination and report.
7	Juvenile court
8	Juvenile court
10	Court psychiatrist
11	Institutional psychiatrist
12	Probation officer and children's clinic
14	The juvenile court
15	Mental hygiene clinic
16	Psychiatrists of County Clinic for Child Study, with assistance of psychologist and psychiatric social worker

Not answering this question -- #2, 5, 9, 13

Answers from Combined Juvenile Courts

2	Court
3	Court can refer to dept. of mental health for examination and report
4	Mental hygiene clinic
5	Receiving home for children
6	Juvenile court refers the case to qualified doctor
7	If the judge "suspects" the condition, he refers the matter to a specialist.
8	State hospital
9	Probation department
14	Juvenile court
16	Child Guidance Clinic. Individual psychiatrists and psychologists

Not answering this question -- #1, 10, 11, 12, 13, 15

Answers from Circuit Court Level

1	Detecting -- sheriff and county attorney; diagnosing -- doctor and judge

APPENDIX E-3

Answers from Circuit Court Level (cont'd.)

Questionnaire #	Person or Agency Having Responsibility
3	Private person or judge
6	Court
8	Agency having charge of person
10	None
11	None
12	Attorney for person on trial or officer in charge of institution to which defendant is sent
13	State hospital
14	The "qualified experts" appointed by the court
17	State hospital for criminal insane
19	Attorney-general or state's attorney may file a petition followed by jury trial
21	Psychiatrists if referred to them by the court
23	A commission of physicians
27	None
31	Attorney-general or state's attorney
37	The court
43	District attorney. Attorney for defendant or the court itself
44	In capital cases, the Supt. of Insane Hosp. or three specialists appointed by the Judge. In other cases, the Judge himself or a jury empanneled to try the one issue of sanity or insanity

Not answering this question -- #2, 4, 5, 7, 9, 15, 16, 18, 20, 22, 24, 25, 26, 28, 29, 30, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42

Answers from Magistrate Court Level

1	County physician and psychologist or neurologist if needed
4	Doctor called in by the court
10	Family court
17	Probate court

Not answering this question -- #2, 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 19

APPENDIX E-4

STAGES AT WHICH DIAGNOSIS IS MADE IN COURTS AND WELFARE AGENCY PROCEEDINGS

Question: If a person is diagnosed a psychopath, at what stage in the proceedings is such a diagnosis made?

a. After case is brought to attention of authorities, but prior to the hearing (or trial)
b. During the hearing (or trial)
c. After hearing (or trial), but prior to commitment (or sentence)
d. After commitment (or after beginning to serve sentence)
e. At some other time (Please specify when)

Answers from State Departments of Welfare

a -- #5, 7, 10, 15, 23
b -- #5, 7, 23
c -- #4, 7, 8, 10, 23
d -- #2, 4, 8, 10, 12, 13, 16, 18, 33
e -- Try to have local workers recognize problems early and bring them to the treatment stage long before bad personality patterns have been established (#7)
Sometimes prior to commitment -- by a children's clinic (#12)
Sometimes during social study (#18)
Not answering this question -- #1, 3, 6, 9, 11, 14, 17, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32

Answers from Independent Juvenile Courts

a -- #1, 2, 3, 6, 7, 11, 12, 15, 16
b -- #1, 11, 12, 16
c -- #1, 5, 8, 10, 11, 16
d -- #1, 11, 16
e -- #1
Between court hearings while on probation (#3)
During time on probation (#10)
#11
When the case is brought to the attention of the court (#14)
After probation has been tried (#16)
Not answering this question -- #4, 9, 13

APPENDIX B-4

Answers from Combined Juvenile Courts

a -- #3, 4, 5, 6, 8, 9, 14
b -- #2, 7, 16
c -- #10
d -- None
e -- None
Not answering this question -- #1, 10, 11, 12, 13, 15
Comments or qualifications:
#3 -- "Whenever possible"
#4 -- "Nearly always"

Answers from Circuit Court Level

a -- #1, 2, 6, 8, 12, 13, 14, 19, 21, 27, 31, 37, 43, 44
b -- #6, 8, 21, 27, 37, 43, 44
c -- #6, 8, 10, 13, 21, 22, 44
d -- #8, 12, 21, 27, 44
e -- At any time it appears that he is in need of a psychopath [sic] (#1)
#8, 21
At any time between arrest and completion of sentence (#44)
Not answering this question -- #3, 4, 5, 7, 9, 11, 15, 16, 17, 18, 20, 23, 24, 25, 26, 28, 29, 30, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42

Answers from Magistrate Court Level

a -- #1, 4, 7, 10
b -- #1, 4, 7, 15
c -- #4, 7
d -- #4, 7
e -- #4, 7
Not answering this question -- #2, 3, 5, 6, 8, 9, 11, 12, 13, 14, 16, 17, 18, 19

APPENDIX E-5

TIME AND METHOD OF MAKING DIAGNOSIS IN STATE MENTAL HOSPITALS AND CORRECTIONAL INSTITUTIONS

Question: If a diagnosis of psychopath is made, is it made
a. Prior to admission to your institution?
What person or agency has responsibility for detecting and diagnosing the psychopath?
b. After admission to your institution?
How detected in your institution?

Answers from Psychiatrists in State Mental Hospitals

a. Prior to admission and by whom:
#7 -- Practicing physicians
#15 -- Committing physicians
#17 -- Medical examiners for courts
#19 -- Lunacy commission
#36 -- Occasionally by other hospital staffs
#37 -- County court behavior clinic
#39 -- In some cases -- Probate Court
#40 -- Physicians in the community
#59
#71 -- Superior court assisted by physicians
#85 -- Court examining psychiatrist
#91 -- Court physicians if psychosis also present
#93 -- Psychiatric dept. -- general hospital
#95 -- Out-patient mental clinic

b. After admission and how:
#1 -- After obtaining history and doing psychiatric examinations
#2 -- History, observation, mental examination
#3 -- History and symptoms
#4
#5 -- Mental examination
#6 -- Staff diagnosis
#7 -- Resident staff psychiatrists
#8 -- Examination and observation
#9 -- First by individual psychiatrist, later classified by psychiatric staff
#10 -- Psychiatric study
#11 -- Examination
#12 -- Mental examination and social history
#13 -- Examinations and clinical conference
#14 -- History and mental tests
#15 -- Constant observation by psychiatric staff
#16 -- By medical staff

APPENDIX E-5

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#17 -- Medical staff
#18 -- Clinical conference
#19 -- Staff
#20 -- History and examination
#21 -- Observation and examination
#22 -- Observation, examination, and history
#23 -- Mental examination
#24 -- Study of history and person
#25 -- History, psychometrist's reports, and psychiatrist's evaluation
#26 -- History and examination
#27 -- Standard clinical methods
#28 -- Studied by medical staff, investigated by social service, and studied by psychologist
#30 -- Study of the case
#31 -- History and conduct at hospital
#32 -- Psychiatric examinations
#33 -- Anamnesis and clinical observation
#34
#35 -- Psychiatric examination
#36 -- Majority vote of the hospital staff when case is presented
#37 -- Psychiatric examination
#38 -- History and examination
#39 -- Routine examination and history
#40 -- Physicians on hospital staff
#42 -- Observation, mental examination, and history
#43 -- Examination
#44 -- Examination
#45 -- Medical staff
#46 -- History and clinical findings
#47 -- Symptomatology
#48 -- History and conduct
#49 -- Staff physician
#50
#51 -- Staff meeting
#52 -- Anamnesis and mental examination
#53 -- Hospital physicians
#54 -- Formal mental examination and history
#55 -- At staff conference after review of case history and mental findings
#56 -- Observation and history
#57 -- History, observation, expression, and behavior
#58 -- Mental examination
#59
#60 -- History and observation

APPENDIX E-5

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#61 -- Observation of behavior pattern
#62 -- Psychiatric and psychological examination
#63 -- Examination
#64 -- History, observation, and staff presentation
#65 -- After thorough examination
#66
#67 -- Examination, history, etc.
#68 -- Staff meeting
#70 -- History and findings, with particular emphasis on evaluating the individual's emotional maturity
#71 -- Occasionally in course of observation and examination by psychiatrists
#72 -- Clinical observation and review of history
#73 -- Clinical and Psychological studies
#74 -- Regular process of examination
#75 -- Psychiatric and psychological study, observation of behavior and evaluation of social history
#76 -- History and examination
#77 -- Examination
#78 -- Routine psychiatric study
#79 -- Ward physicians
#80 -- Psychiatric examinations, indicated physical and laboratory examinations
#81 -- In course of psychiatric examination
#82 -- Examination and history
#83 -- Staff meeting after examination
#84 -- History and observation
#86 -- History and examination
#87 -- Current mental tests by staff
#91 -- Clinical staff
#93 -- Integration of mental and physical findings and social history
#94 -- By routine psychiatric history and examination methods
#95 -- Routine mental, physical and psychological examination

Not answering this question -- #29, 41, 69, 88, 89, 90, 92

Answers from Psychiatrists Attached to Correctional Institutions

a. Prior to admission and by whom:
#6 -- Medical staff at referring institution
#7 -- Court declares all of ours feeble-minded

APPENDIX E-5

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

#10 -- May be caught in out-patient examinations
#11 -- Mental hygiene clinics
#12 -- Out-patient psychiatric clinics
#22 -- Psychiatrist and psychologist
#24 -- Other psychiatrists
#29

b. After admission and how:
#1 -- Psychiatric study
#2 -- Psychiatric study
#3 -- Examination by psychiatrist
#4 -- Psychiatric examination and observation
#5 -- Study of history, behavior pattern and physical examination
#6 -- By medical staff after observation and examination
#7 -- Psychiatric examination
#8 -- Psychological tests, clinical interview, social history
#9 -- Psychological staff
#10 -- Medical staff diagnosis
#12 -- Psychiatric observation
#13 -- Classification officer and prison physician
#14 -- Psychiatric appraisal
#22 -- Observation, study and review of case history
#23 -- Senior prison physician
#24 -- Psychiatric examination
#25 -- Examination by psychologist and psychiatrist
#26 -- Prison physician
#27 -- Psychiatrist
#28 -- Staff study
#29 -- Examination

Not answering this question -- #15, 16, 17, 18, 19, 20, 21, 30

Answers from Psychologists in Correctional Institutions

a. Prior to admission and by whom:
#2 -- State and court clinics
#4 -- Child guidance clinics
#5 -- Mental hygiene clinics

b. After admission and how:
#1 -- Psychiatrist
#2 -- Family background, personal and delinquency history, impressions obtained in personal interview

APPENDIX E-5

Answers from Psychologists in Correctional Institutions (cont'd.)

#3 -- History, test results, behavior in institution
#4 -- Study by psychologist
#5 -- Psychological examinations
#6 -- Clinical examination and case history
#7 -- Psychologist and psychiatrist available for examination
#8 -- Psychiatric and psychological examinations

Answers from Superintendents of Juvenile Correctional Institutions

a. Prior to admission and by whom:
#3 -- Service is available if juvenile judge uses it
#5 -- Officials from county from which inmates are sentenced
#8 -- Receiving home
#13 -- The court, or the Bureau of Juvenile Research
#14 -- Child Guidance Clinic for a few commitments
#17 -- Psychiatrist at juvenile court
#18 -- Probation dept. of state
#22 -- Psychiatrist in state hospital
#32 -- Juvenile court
#35
#37 -- Local mental hygiene clinics (Psychiatrists on state staff)

b. After admission and how:
#1 -- Neuropsychiatric exam and observation of behavior over a period of many months
#2 -- Clinic and case conference
#3 -- Visiting psychologist; or if suspicious, we take to specialist
#4
#6 -- Each girl admitted is examined by physician; girls with behavior problems are referred to school psychiatrist
#7 -- Study of behavior problems
#8 -- Referred to receiving home or state hospital
#9 -- Visiting psychologist
#11 -- Psychiatrist or staff
#12
#13 -- By behavior -- by the Bureau of Juvenile Research
#14 -- Part-time psychiatrist
#15 -- State psychologist
#16 -- Through peculiar behavior, followed by tests given by the psychologist

APPENDIX E-5

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

#17 -- By the psychologist or by observation of adjustment to others
#22 -- Diagnosis of psychologist
#31 -- Observation and judgment of psychiatrist
#32 -- Observation by staff untrained in psychiatry
#33 -- Testing and observation here and at mental hospital
#34 -- By continuous negativistic behavior
#35 -- Transferred to mental institution for observation
#36 -- Our psychiatrist or the psychiatrist of the Juvenile Court
#37 -- Our state psychiatrists
#38 -- Studied at psychiatric clinics at our request

Other answers:
#10 -- Provision for psychiatric exam available in very few cases
Not answering this question -- #19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30

Answers from Superintendents of Adult Correctional Institutions

a. Prior to admission and by whom -- None
b. After admission and how:
#1 -- By behavior -- followed by examinations by psychologist and psychiatrist
#2 -- Supt. or any member of the classification committee
#3 -- Actions
#4 -- Observation in quarantine (2 wks.) by doctor and nurses. Examination by visiting psychiatrist
#5 -- Board of examining psychiatrists
#6 -- Prison Sanity Board
#7 -- Only when the condition becomes quite evident -- than examination is given by calling in member of staff of State Mental Hospital
#9 -- Prison physician through behavior reports
#10 -- Occasionally transferred to hospital by observation of officers and physician
#11 -- By close contact and observation by supt., staff, and physician
#13 -- By physician

APPENDIX E-5

Answers from Superintendents of Adult Correctional Institutions (cont'd.)

#14 -- Upon advice of others or behavior of inmates
#15 -- Psychiatric examination and observation
#16
#17 -- Psychiatric study
#23 -- By close personal observation and contact made with inmate by warden and the other prison officials
#26 -- If we observe psychopathic tendencies, apply to office of commissioner of mental hygiene, and a psychiatrist is sent to examine the inmate
#27 -- Examination by psychologist and neuro-psychiatrist

Not answering this question -- #18, 19, 20, 21, 22, 24, 25

Comments and qualifications:
#8 & 12 -- None made
#16 -- If made

APPENDIX E-6

PSYCHIATRIC AND PSYCHOLOGICAL SERVICES AVAILABLE IN CORRECTIONAL INSTITUTIONS, WELFARE AGENCIES, AND COURTS

Question: Is there a psychiatrist or psychologist available for use in your work?

a. Yes
   (1) Psychiatrist
      (a) Attached (to court, institution, or department) full-time
      (b) Attached part-time
      (c) Specialist called in, or specialist to whom cases are sent
   (2) Psychologist
      (a) Attached full-time
      (b) Attached part-time
      (c) Specialist called in, or specialist to whom cases are sent

b. No

Answers from Psychiatrists Attached to Correctional Institutions

a.(1)(a) -- #23, 24, 27
a.(1)(b) -- #22, 25
a.(1)(c) -- #26
a.(2)(a) -- #22, 23, 24, 27
a.(2)(b) -- #25
a.(2)(c) -- None
b. -- None

Answers from Psychologists in Correctional Institutions

a.(1)(a) -- #6
a.(1)(b) -- #7, 8
a.(1)(c) -- #2, 3, 5
a.(2)(a) -- #1, 2, 4, 5, 6, 7, 8
a.(2)(b) -- #3
a.(2)(c) -- None
b. -- None

APPENDIX E-6

Answers from Superintendents of Juvenile Correctional Institutions

a.(1)(a) -- #2, 11
a.(1)(b) -- #1, 6, 14, 36, 37
a.(1)(c) -- #2, 4, 5, 7, 8, 9, 12, 13, 15, 16, 18, 20, 33, 35, 38
a.(2)(a) -- #2, 8, 10, 11, 13, 16, 17, 21, 22
a.(2)(b) -- #6, 7, 9, 12, 31, 33, 37
a.(2)(c) -- #3, 8, 15, 29, 38
b. -- #19, 23, 24, 30, 32
Not answering this question -- #25, 26, 27, 28, 34

Answers from Superintendents of Adult Correctional Institutions

a.(1)(a) -- None
a.(1)(b) -- #11, 15, 17
a.(1)(c) -- #1, 2, 3, 4, 5, 6, 8, 9, 13, 14, 18, 20, 26
a.(2)(a) -- #15
a.(2)(b) -- #1, 11
a.(2)(c) -- #2, 3, 6, 9, 10, 13, 14
b. -- #7, 12, 18, 19, 23, 24, 25
Comments or qualifications:
#16 -- "All mental cases turned over to superintendent of state hospital"
#17 -- "Psychiatric consultant comes to this institution once in 5 weeks."
#20 -- "The only work done along this line is by one of the psychiatrists from the State Hospital."
#26 -- "Can apply for help to office to commissioner of mental hygiene."
Not answering this question -- #21, 22, 27

Answers from State Departments of Welfare

a.(1)(a) -- #4, 8, 21, 33
a.(1)(b) -- #2, 6
a.(1)(c) -- #1, 5, 7, 12, 15, 17, 20, 22, 23
a.(2)(a) -- #2, 4, 6, 7, 8, 12, 15, 16, 25, 33
a.(2)(b) -- #17, 20
a.(2)(c) -- #1, 5, 10, 15, 22, 23
b. -- #9, 11, 13, 14, 18, 29
Comments or qualifications:
#1 -- "For diagnostic services only and on a limited scale"
#2 -- "Position vacant"

APPENDIX E-6

Answers from State Departments of Welfare (cont'd.)

#13 -- "Except as individual cases are referred to Child Guidance Clinic of state university"
Not answering this question -- #3, 19, 24, 26, 27, 28, 30, 31, 32

Answers from Independent Juvenile Courts

a.(1)(a) -- #8, 11
a.(1)(b) -- #3, 10, 14, 16
a.(1)(c) -- #1, 2, 4, 5, 6, 7, 12, 14, 15
a.(2)(a) -- #3, 6, 16
a.(2)(b) -- #10, 14
a.(2)(c) -- #1, 2, 4, 5, 7, 15
b. -- #9
Not answering this question -- #13

Answers from Combined Juvenile Courts

a.(1)(a) -- None
a.(1)(b) -- None
a.(1)(c) -- #3, 4, 6, 7, 8, 9, 10, 14, 16
a.(2)(a) -- None
a.(2)(b) -- None
a.(2)(c) -- #3, 4, 5, 6, 7, 8, 9, 14, 16
b. -- #2, 11, 12, 13
Not answering this question -- #1, 15

Answers from Circuit Court Level

a.(1)(a) -- None
a.(1)(b) -- None
a.(1)(c) -- #1, 6, 7, 10, 12, 19, 20, 21, 23, 25, 27, 28, 31, 32, 35, 36, 37, 43
a.(2)(a) -- None
a.(2)(b) -- None
a.(2)(c) -- #6, 21, 25, 28, 32
b. -- #2, 3, 5, 8, 9, 11, 13, 14, 15, 16, 17, 18, 22, 24, 26, 29, 30, 33, 38, 44
Comments or qualifications:
#26 -- "Except commission of physicians"
Not answering this question -- #4, 34, 39, 40, 41, 42

APPENDIX E-6

Answers from Magistrate Court Level

a.(1)(a) -- None
a.(1)(b) -- None
a.(1)(c) -- #1, 7, 8, 10, 18
a.(2)(a) -- None
a.(2)(b) -- None
a.(2)(c) -- #7, 18
b. -- #2, 4, 6, 9, 12, 13, 14, 16, 17
Not answering this question -- #3, 5, 11, 15, 19

APPENDIX E-7

EXTENT OF PROVISION FOR RE-EXAMINATION

Question: If a person is once diagnosed a psychopath, is there provision for re-examination in order to determine the accuracy of the first diagnosis?

a. Yes
   At what intervals? _____
b. No

Answers from Psychiatrists in State Mental Hospitals

Answering "Yes" and stating intervals:

#1 -- Accuracy of diagnosis is kept in mind and changed if necessary
#2 -- 6 months
#3 -- Constant rechecking as in all other cases
#4 -- 3 months
#5 -- Frequent intervals
#7 -- Not oftener than 6 months
#8 -- Every few months
#9 -- Any time that individual psychiatrist or group of psychiatrists may deem it advisable
#10 -- Advise 6 months
#11 -- Any time
#12 -- Depends on decision of physicians
#13 -- As occasion demands
#14 -- 6 months
#15 -- Whenever the routine daily psychiatric observation determines the need
#16 -- Monthly
#17 -- 3 to 6 months
#18 -- Indefinite until determined at our staff meetings
#19 -- 6 months
#20 -- No stated interval
#21 -- 3 months
#22 -- Irregularly
#23 -- 10 days to 2 weeks
#24 -- Change in diagnosis may be made at any time
#25 -- 6 months
#26 -- No regular intervals
#27 -- About every 4 to 6 months
#28 -- As situation requires -- no specific intervals
#30 -- One year from release
#31 -- As necessary
#33 -- He is seen at frequent intervals and the diagnosis changed if subsequent behavior indicates this
#34 -- Varied
#35 -- 2 wks., 2 mos., and 6 to 12 mos. after admission

APPENDIX E-7

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#36 -- For parole consideration at varying intervals
#37 -- Month
#38 -- Irregular
#39 -- Irregular
#40 -- As required for purposes of committment, parole, readmission, etc.
#42 -- Observation monthly and six months examination
#43 -- Same as other patients
#44 -- Monthly
#45 -- No definite intervals
#46 -- Continuous observation
#47 -- 3 months
#48 -- 1 month, 3 months, and indefinite terms
#49 -- Seen daily by staff physician
#50 -- Three months
#51 -- 3 months
#52 -- No special intervals
#53 -- As considered necessary by assistant physicians
#54 -- At any time that release from the hospital is being considered
#55 -- Varies considerably
#56 -- Daily observation by staff -- in 3 to 6 months
#57 -- Yearly
#59 -- Once or twice a year
#60 -- At parole and at discharge from parole
#61 -- 6 months
#62 -- 1 year
#64 -- 6 months
#65 -- Diagnoses are revised as soon as it is felt that there is an error
#68 -- 6 months
#70 -- After 6 months, and again at yearly intervals
#71 -- All patients are re-examined 4 times a year
#74 -- At any time in the judgment of the medical staff
#75 -- 90 days
#76 -- Every 3 months
#77 -- No definite time set
#78 -- When considered for release
#79 -- 3 months
#81 -- Same as other patient population
#82 -- No stated interval
#83 -- When indicated
#84 -- No set interval
#85 -- Monthly
#86 -- No regular time except once, 1 month after admission

APPENDIX E-7

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#93 -- Occasionally
#95 -- Monthly during first 6 months, semi-annually thereafter (if psychotic); on discharge advised to obtain advice from out-patient mental clinic

Answering "Yes" but not stating intervals -- #67, 73, 80, 92
Answering "No" -- #6, 32, 58, 63, 66, 87, 91, 94
Not answering this question -- #29, 41, 69, 72, 88, 89, 90
Comments or qualifications:
#31 -- "If there is reasonable doubt
#87 -- "If correctly classified should not require re-classification"

Answers from Psychiatrists Attached to Correctional Institutions

Answering "Yes" and stating intervals:
#1 -- When adjustment problems arise; when considered for parole, release, transfer, etc.
#2 -- 1-6 months
#3 -- One year
#4 -- Every few months
#5 -- When circumstances indicate
#6 -- At least annual review and before release
#7 -- As needed
#8 -- Prior to eligibility for parole
#9 -- About once a year
#11 -- Annual
#13 -- Only when anti-social behavior presents itself
#14 -- Varies
#15 -- Upon referral to this institution -- psychopaths are not admitted
#22 -- Every four months
#23 -- None
#24 -- As necessity requires
#25 -- When up for parole -- 6 to 12 months
#26 -- No stated intervals
#27 -- At least annually
#28 -- No stated intervals. When change in behavior is noted

Answering "Yes" but not stating intervals -- #29
Answering "No" -- #10
Not answering this question -- #12, 16, 17, 18, 19, 20, 21, 30

APPENDIX F-7

Answers from Psychologists in Correctional Institutions

Answering "Yes" and stating intervals:
- #5 -- 3 or 4 months
- #6 -- 4 to 6 months
- #7 -- Every 2 months
- #8 -- No specified intervals

Answering "Yes" but not stating intervals -- #2
Answering "No" -- #1, 4
Not answering this question -- #3
Comments or qualifications:
- #7 -- "This is still more in theory than in practice since the psychotic (insane) get most of the attention"

Answers from Superintendents of Juvenile Correctional Institutions

Answering "Yes" and stating intervals:
- #1 -- About once a year
- #2 -- Not over 6 months
- #3 -- As soon as we can get them transferred to Receiving Center
- #5 -- Three months
- #6 -- Psychiatrist follows this through as necessary
- #7 -- Determined by psychiatrist in the University Hospital
- #8 -- Before parole
- #11 -- 6-12 months
- #13 -- Before parole and after trial on parole or return to institution
- #14 -- 2 months
- #18 -- Previous to transfer to other institutions
- #22 -- No specific time limits. Re-examination given when it is felt that the individual is in need of further study and diagnosis
- #31 -- As needed
- #35 -- Observation period
- #36 -- When requested
- #37 -- As often as recommended by clinic
- #38 -- Determined by psychiatrist on case

Answering "Yes" but not stating intervals -- #12, 15, 16, 33
Answering "No" -- #4, 10, 17, 32
Not answering this question -- #9, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 34

APPENDIX E-7

Answers from Superintendents of Adult Correctional Institutions

Answering "Yes" and stating intervals:
- #1 -- Necessitated by behavior
- #2 -- Any classification meeting
- #3 -- Every 3 months
- #4 -- Varying periods -- a month, 2 months, as indicated
- #5 -- Can be done prior to final release and after transfer to mental hospital
- #9 -- At state hospital to which he has been transferred
- #10 -- As often as the physician recommends the transfer to hospital, or when we have taken all we can bear and hope for a commitment elsewhere
- #11 -- As often as necessary
- #13 -- Annually
- #14 -- As may be determined by resident physician
- #15 -- No definite intervals. All are re-examined when they come before the Court of Pardons or for parole
- #16 -- Varied
- #17 -- As indicated
- #27 -- When becoming eligible for parole or release

Answering "Yes" but not stating intervals -- #6
Answering "No" -- #7, 12, 18, 19, 20, 24
Not answering this question -- #8, 21, 22, 23, 25, 26

Answers from State Departments of Welfare

Answering "Yes" and stating intervals:
- #2 -- No routine procedure. Reexamination is possible if there appears to be change or if it necessary for further planning
- #4 -- Cases are always under observation
- #5 -- Whenever indicated
- #10 -- No definite plan
- #12 -- 6 months
- #15 -- Continual
- #23 -- If need is indicated
- #33 -- At request

Answering "Yes" but not stating intervals -- #16
Answering "No" -- #13, 18
Not answering this question -- #1, 3, 6, 7, 8, 9, 11, 14, 17, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32
Comments or qualifications:
- #13 -- "Except in case by case basis"

APPENDIX E-7

Answers from Independent Juvenile Courts

Answering "Yes" and stating intervals:
- #1 -- When necessary
- #4 -- Whenever indicated
- #7 -- No regulation
- #8 -- No hard and fast rule
- #10 -- After three months if child is not committed or carried for treatment to psychiatric clinic
- #11 -- Whenever progress indicates wrong original diagnosis
- #12 -- No regular intervals
- #14 -- As often as necessary
- #15 -- As recommended by clinic
- #16 -- Upon petition to court making adjudication

Answering "Yes" but not stating intervals -- #5
Answering "No" -- None
Not answering this question -- #3, 9, 17
Comments or qualifications:
- #2 -- "Juveniles can be brought before the court or orders changed at any time 'til age 21."

Answers from Combined Juvenile Courts

Answering "Yes" and stating intervals:
- #3 -- As often as change indicates modification of treatment
- #4 -- As frequent as court requests
- #5 -- Several months
- #7 -- No definite time
- #9 -- When considered necessary or helpful
- #16 -- As suggested by heads of institutions

Answering "Yes" and not stating intervals -- #8
Answering "No" -- #2, 6
Not answering this question -- #1, 10, 11, 12, 13, 14, 15

Answers from Circuit Court Level

Answering "Yes" and stating intervals:
- #6 -- Any time
- #19 -- Trial by jury on question of recovery
- #21 -- Determined by experts
- #27 -- At any time the warden certifies as to changed condition

APPENDIX E-7

Answers from Circuit Court Level (cont'd.)

#31 -- Any time the person desires the question of his recovery decided by a jury
#37 -- When necessary
#44 -- When hospital doctors report that he has improved sufficiently

Answering "Yes" and not stating intervals -- #1, 3, 8, 16
Answering "No" -- #9, 10, 11, 13, 14, 15, 17, 22, 24, 28, 43
Not answering this question -- #2, 4, 5, 7, 12, 18, 20, 23, 25, 26, 29, 30, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42
Comments or qualifications:
#3 -- "As incident to commitment to hospital for insane."

Answers from Magistrate Court Level

Answering "Yes" and stating intervals:
#4 -- At any time
#10 -- As prescribed by family court

Answering "Yes" and not stating intervals -- #6
Answering "No" -- #1, 2, 9
Not answering this question -- #3, 5, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19

APPENDIX E-8

TERMINOLOGY EMPLOYED AND DEFINITION OR DESCRIPTION USED FOR DIAGNOSIS

Question: If there is some similar term which you use instead of "psychopath," please give that term here _____, and substitute that term for the term "psychopath" in the questions below.
What definition or description of the psychopath serves as a guide for diagnosis in your work?

Answers from Psychiatrists in State Mental Hospitals

Similar term used:
- Psychopathic personality -- #2, 5, 12, 14, 15, 21, 25, 37, 40, 54, 70, 74, 80, 81, 94
- Constitutional psychopathic inferiority -- #10, 31 (rarely used)
- Psychopathic constitutional state or psychopathic personality -- #18
- Psychopathic personality or constitutional psychopath -- #20
- Constitutional psychopathic personality -- #56
- Favor pathological personality over psychopathic personality -- #62

Definition or description:

#1 -- That of Henderson and Gillespie as stated in their textbook, "Under this heading we include persons who have been from childhood or early youth habitually abnormal in their emotional reaction and in their general behavior, but who do not reach, except perhaps episodically, a degree of abnormality amounting to certifiable insanity, and who show no intellectual defects."

#2 -- Moral defective - basic personality defect which does not allow the individual to recognize the rights of others where these rights conflict with his desires. Even after punishment for antisocial acts, he is unable to utilize this experience to guide him in avoiding future acts of an antisocial nature.

#3 -- Cases showing abnormal reactions, essentially of an emotional and volitional nature, apparently on the basis of constitutional defect, who do not fit into the other types of functional mental disorders. Cases of intellectual defect are not included.

Psychopathic personality is characterized largely by emotional immaturity or childishness with marked

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#3 (cont'd.) -- defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others, and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage and sexual perversions. Intelligence may be normal or superior but not infrequently a borderline intelligence may be present.

#4 -- Social misfit. His complete life history is considered.

#5 -- As defined in Statistical Manual published by National Committee for Mental Hygiene.

#6 -- That as stated in the Statistical Manual for hospitals for Mental Diseases of the American Psychiatric Association and National Committee for Mental Hygiene, 1942.

#7 -- The psychopath may be considered as a character of behavior disorder with development of disturbing pathological trends in the personality structure with little or no subjective anxiety or distress. These patients present behavior in which they act out their symptomatology rather than by presenting emotional or mental symptoms. They may not progress to a stage of psychosis and also do not present features of a well developed neurosis. They are the individuals, who, in spite of a fairly normal background, are always in trouble and fail to profit either by experience or punishment, and cannot be trusted in the matter of relationships with other members of society. While not truly criminal type, their character and behavior in many instances lead them to become easy prey for the criminal element, as a result of which they themselves become involved. These are the individuals who turn up as gansters and vagabonds, racketeers, etc. They frequently progress to specific types of pathological sexual behavior.

#8 -- Most psycho-paths are auto erotic, that is they have never learned to be small fish. They are still in love with themselves. They have failed to completely pass through the successive stages of psychosexual development into homo-sexuality and hetrosexuality, but have carried over into adult life certain "pre-adult" tendencies that are out of place in a normally hetero-sexual world, etc., and a lot more. The most gullible people are the <u>good</u> people,

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#8 (cont'd.) -- who long since have given up their bad traits, etc.

#9 -- Essentially that designated in the "Statistical Manual for the use of Hospitals for Mental Diseases." Published by the National Comm. for Mental Hygiene.

#11 -- Accepted classical description

#14 -- The psychopathic personality is characterized by an emotional immaturity or childishness, a marked lack of judgment and an inability to learn from experience.

#15 -- A psychopathic personality is an individual not mentally defective or showing frank organic pathology of the central nervous system, who from birth or early life shows a failure of normal development in the emotional and volitional spheres. The psychopath is unable to understand, appreciate or sympathize with the feelings and attitudes of others, is self-centered, does not profit by experience and shows a persistent faulty judgment and a lack of emotional control. They are also likely to be unable to show a persistent effort toward a goal and their interest is apt to lag easily. When they develop a psychosis it generally consists of an episode of emotional instability or the formulation of paranoid trends. They are especially susceptible to a psychotic breakdown when under close confinement.

#16 -- An individual who is guided by his emotions rather than intellect and has shown evidence of failing to profit by experience or training.

#17 -- Classification of American Psychiatric Association.

#18 -- Defect and not a pathologic alteration. Defect more serious than feeblemindedness as it involves emotional instability and greater involvedness in moral and more serious ethical judgment.

#20 -- Since Dr. Henderson has written a book describing the condition probably better than anyone else, I hesitate to offer a definition that is in any way comprehensive.

#21 -- That given by Streiker and Ebaugh's Clinical Psychiatry, Fourth Edition, p. 468 -- "We feel that in true psychopathic inferiority the primary consideration is a defect state. This defect is not like that found in mental deficiency which involves primarily the intellectual assets of the patient, but a defect consisting of an apparent constitutional lack of

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#21 (cont'd.) -- responsiveness to the social demands of honesty or truthfulness or decency or consideration for others and perhaps, chiefly an inability to profit by experience."

#22 -- In this institution, we have cases who have exhibited anti-social behavior of mild or moderate degree, which is not amenable to change through advice or experience, and which is repetitive in character, and which occurs in spite of apparent understanding of point that such behavior is undesirable and in spite of apparent intention to change.

#23 -- These, of course, are diagnosed by a close study and mental observation of personality, mannerisms, ideas and habits.

#24 -- The psychopath suffers from a character defect.

#25 -- Persons with an uncontrollable impulse to engage in asocial or antisocial behavior, unaffected by (or at best, resistant to) persuasion, education, and punishment, whose behavior may be associated with but is not dependent upon psychosis or feeblemindedness.

#26 -- Moral deficiency -- "amorality"
Lack of delusions
Absence of hallucinations
Frequent conflicts with authorities

#27 -- Psychopathic personality is a descriptive term applied to individuals who from the childhood level are relatively unable to withstand anxiety arising from restricted libidial cathexes and habitually employ asocial mechanisms to allay this anxiety.

#28 -- A psychopath is one who shows lack of interest, his judgment is defective, he is immature emotionally and fails to learn from experience.

#30 -- We follow the nomenclature of the National Committee for Mental Hygiene.

#31 -- A type of personality afflicted with diminished volitional control and heightened emotional response to stimuli.

#32 -- Immature childish judgment. Emotional blunting. Marked egocentric tendencies. Frequent entanglements with law and order dating to relatively early age. Inability to make parental adjustments. Complete lack of sense of responsibility.

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#33 -- The guide for nomenclature of the American Psychiatric Association. This however is not very explicit and leaves a wide range for interpretation including individuals who are constantly or infrequently getting into difficulties without profiting by experience. They have a lack of will power and usually demonstrate disturbed family relationships either overt or active. They include "the constitution" types as well as "developmental" or "environmental" types. They demonstrate abnormal reactions of an emotional or volitional nature (not intellectual defect) with emotional immaturity and defects.

#34 -- No definition can apply to all individuals but generally speaking, a psychopath is an individual that acts upon the spur of the moment regardless of the consequence of his act, and rarely learns from experience.

#35 -- An individual of apparent average intelligence, with average educational and social opportunities; who has no or few neurotic symptoms and no psychotic symptoms (like dementia, delusions or hallucinations); who nevertheless shows inability to get along; with pathological emotionality, alcoholism or sexuality; and with anti-social or even criminal acts or tendencies.

#36 -- Defective social concepts, with egocentricity, disregard of laws, conventions, the rights of fair play; fundamental maladjustment with antisocial acts, repeated litigation, psychic and emotional instability, and amoral attitude toward society.

#37 -- They constitute a group who may or may not be of average or above average intelligence and who because of emotional instability or because of an inability to learn from experience are unable to adjust to the usual requirements of their particular corner or strata of society. Thus, in spite of the presence or absence of intellectual ability, they cannot intelligently control their actions in relationship to their fellow men.

#38 -- In my judgment, a constitutional psychopath is one who is lacking in judgment and inhibition to an extent that they are not able to compete with the ordinary individual in making an honest living, become wanderers, are easily led to commit crimes or acts against the laws of the community in which he is living, and therefore to become frequently

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#38 (cont'd.) -- committed to penal institutions or training schools, and who then eventually probably become psychotic.

#39 -- Use Henderson's definition.

#40 -- Those which apply with closest approximation, and which are most useful; including the formulations of Adolph Meyer, Eugen Kahn, the Freudian school, and the nomenclatives of the National Committee of Mental Hygiene, of the Army, of the Navy, etc.

#42 -- We usually have a history of the patient blaming everyone for his difficulties. He expands on his talk in regard to those that mistreat him and we find that he is unable to make pleasant adjustments, that he is constantly getting into difficulties which he has no explanation for.

#43 -- Determined by psychiatric examination, also social history.

#45 -- Psychopathic personality is a condition either hereditary, congenital, or acquired, affecting the emotional and volitional rather than the intellectual fields and manifested by certain anomalies of character which make satisfactory social adjustment difficult or impossible.

#46 -- Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning from experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, mental deficiency, vagabondage and sexual perversions. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently a borderline intelligence may be present.

#47 -- Statistical Manual of National Committee for Mental Hygiene used for diagnosis, but wholly inadequate.

#48 -- An intelligent person who fails to learn to adjust emotionally chiefly because of lack of emotional qualities.

#49 -- Not responsible
Not dependable
Criminal traits

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#49 (cont'd.) --
Do not learn from experience
Emotionally cold, etc.
Think they are smart if allowed to go unpunished and feel that they have been wronged and abused if apprehended and punished.

#50 -- A psychopathic personality is a condition either hereditary, congenital or acquired, affecting the emotional and volitional rather than the intellectual fields and manifested by certain anomalies of character which make satisfactory social adjustment difficult or impossible.

#51 -- Instinctive, emotional and volitional deviations in all directions. Affective peculiarities in foreground. Psychopaths are essentially thymopaths. Intelligence has little or no regressive effect on behavior. Emotional immaturity and instability prominent, psychosexual life distorted, alcoholism frequent. Do not learn by experience.

#53 -- Definition as given in the statistical manual for the use of hospitals for mental diseases.

#54 -- A general term applied to a certain group, physical, emotional factors which are either inherited or acquired in the early years of life. The diagnosis is largely based upon the anamnesis obtained and formal mental examination serves as a point in ruling out various other conditions.

#55 -- A person who has not profited by experience; has no ethical or moral judgment; is the yardstick we use in diagnosing psychopathic personality.

From personal experience, the writer has learned not to put any confidence in psychopathics, as they invariably betray that confidence.

#56 -- Usually history from early childhood of being behavior problem, deceiving and offending, inadjustable at home, in school and society, generally, with offences increasing in importance to theft, robbery, alcoholism, drug addition, yielding always to evil influences, seeking association with other offenders, easily influences to violate and offend and difficult to influence in good behavior.

#57 -- Disregard for the "superego"
2. Constant friction with the law or environment
3. Undesirable habits from early youth
4. Disregard for the past personal experiences

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#58 -- Lacking in emotional control, moral sensibilities, will power, and ability to learn from experience.

#60 -- Emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience.

#61 -- An ingratiating, usually nice appearing individual, whose behavior and adjustment pattern shows streaks of repeated episodes of irresponsible, antisocial, erratic and well-nigh uncomprehensible behavior.

#62 -- Psychopathic personality is a condition either hereditary, congenital or acquired affecting the emotional and volitional rather than the intellectual fields and manifested by certain anomalies of character which make satisfactory social adjustment difficult or impossible. The psychopath is characterized by deficiency of moral or ethical sense, complete self-satisfaction, emotional instability, social incompatability, poverty of sentiment, sexual deviation, social conspicuousness, lack of fixity of purpose, marked tendency toward shiftiness, nonconformity to accepted social conventions, many undesirable personality traits and unresponsiveness to training, discipline or treatment.

#65 -- Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage and sexual perversions. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may be present.

#66 -- Past history and conduct; not able to profit by past experiences.

#67 -- See Statistical Manual for Use of Hospital for Mental Diseases, prepared by the Committee on Statistics of the American Psychiatric Association in collaboration with the National Committee for Mental Hygiene, 1790 Broadway, New York City.

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#68 -- There are two categories of psychopaths. The first, related to psychic trauma in childhood due either to no father or poor father figures in the environment, or due to excessive frustration leading to a very poor development of ego ideal and super ego. This psychopath is characterized chiefly by impulse ridden tendencies. This psychopath is modifiable by extensive psychotherapy in an institutional environment that is analytically oriented.

The second type of psychopath is one very similar obviously to the first type but the electroencephalogram usually shows evidences of abnormal cerebral electrical activity similar to psychomotor epilepsy. This latter type is not modifiable by psychotherapy but can be helped by a combination of psychotherapy and some chemotherapy such as the use of dilantin or triodine.

#70 -- At our staff we consider a man who is emotionally immature and has difficulty in identifying himself with other people in abstract situations as a suspected psychopathic personality. We then look very carefully for a history of patient's past behavior to indicate whether he has a typical psychopathic background or not. My own opinion is that there are many psychopathics who develop psychoses and psychoneuroses and are called either psychotic or psychoneurotic without a physician recognizing that this individual has an emotional immaturity on the basis of a constitutional element. I think of psychopathic personalities as being "active" and "passive." Passive psychopathics are prone to develop psychoneurotic and neurotic material, or even psychotic. Active psychopathics are the class which give rise to our typical asocial maladjustment behavior. Active psychopathics with aggression towards society on the basis of hatred of authority in a father image, and with addition, a feeling of rejection by the mother, or mother image, are prone to develop criminalism. Passive psychopathics who feel rejection, but no hatred of the father image, are prone to develop sexual neuroses.

#71 -- Absence of psychosis, inability to adjust to environment, conflicts with social order, egotism and expansiveness, paranoid trends, no profit from experience.

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals
(cont'd.)

#72 -- In view of the relatively poor success to date in defining the term psychopathic personality, a completely satisfactory definition of psychopathic personality has never come to my attention and I would not presume to offer one. Nevertheless, it is a term which is valid as relating to certain deviates who although not psychotic and not feebleminded are so organized that they are incapable of adapting themselves adequately to the ordinary requirements of living in an organized society. They are characterized mainly by the accentuation of certain traits of a sufficient degree to mark them as odd, peculiar, unstable, emotionally immature, impulsive or selfish, and with little ability to profit by experience. They may display a singular degree of perspicacity and understanding in certain directions but personal insight relative to their own actions is inadequate and distorted. Criminal and definitely antisocial trends are not necessarily present. Under reasonably favorable conditions many of them can have a fairly useful and successful existence. Others under the most tranquil environment and fortunate circumstances are misfits, frequently rebellious, living tempestuous lives or, at best, achieving good adjustments for brief periods only.

#73 -- Psychopathic personalities fall into two main groups -- the asocial and amoral type and sex perverted type. The first of these show uninhibited instincts, asocial and criminal behavior with recidivism. Lack of ethical and moral sense. Disregard for convention and the standard set by society. They are egotistical, disloyal to family and others and show a ready tendency to project their own faults onto others.

The sex perverted type are those incapable of normal heterosexual adjustment but find pleasure and relief from tension through perversion -- such as exhibitionism, fellatio, lesbianism, etc.

#74 -- "That individual who is apparently unable to adjust himself to his environment as normal persons do" -- Most of these individuals recognize the difference between right and wrong but apparently do not possess the necessary inhibitory powers to resist the commission of anti-social acts.

I thoroughly agree with Dr. L. K. Henderson's

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#74 (cont'd.) -- recent statement relative to the so-called psychopathic personality or his (Dr. DKH) terminology the "psychopath" or "psychopathic constitution." Much work needs to be done from medico-legal standpoint relative to the psychopathic personality group.

#75 -- Chronic antisocial behavior.

#76 -- An individual showing abnormal emotional and volitional reactions on basis of constitutional defect -- emotional immaturity, defects of judgment, with inability to learn by experience.

#77 -- Description in Statistical Manual for Hospitals for Mental Diseases of National Committee for Mental Hygiene.

#78 -- That set down by the American Psychiatric Association.

#79 -- ?

#80 -- Under psychopathic personality, is included that heterogenuous group who show borderline asocial behavior. These individuals are egocentric, have no concern for others, will pursue their own pleasures irrespective of the consequences, and fail to profit by past experience. We recognize certain groups -
(1) with pathological sexuality
(2) with pathological emotionality
(3) with asocial and amoral trends of mixed types

#81 -- Psychopathic personality is a condition either hereditary, congenital or acquired, affecting the emotional and volitional rather than the intellectual fields and manifested by certain anomalies of character which make satisfactory social adjustment difficult or impossible.

#82 -- A departure from normal level of basic judgment. Usually not obvious but from history.

#84 -- Always maladjusted. They lie, steal, get married several times without the formality of getting divorce, are not dependable. May be prostitute. They do not fit into society.

#85 -- Medically: emotional instability and defective judgment.
Legally: They know right from wrong but choose to do wrong. They never learn by experience; do not respect the rights of others.

#86 -- Irresponsible, immature, pleasure-first reaction; spoiled-child reaction type -- with strong probability of doing over and over at varying intervals the anti-social behavior characterizing their problem.

APPENDIX E-8

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#87 -- Those outlined in current recent texts on psychiatry.

#91 -- That contained in the "Statistical Manual for the Use of Hospitals for Mental Diseases," published by National Committee for Mental Hygiene.

#93 -- An individual who engages in anti-social behavior, who acts out his life's conflicts, who sacrifices future security for present day enjoyment and does not learn from experience.

1. One who appears incapable of sustained effort or attention.
2. Does not benefit from experience as much as he should.
3. Concerned only with the immediate present.
4. Is quickly and easily bored and discouraged.
5. Unreasonable resistance to authority is connected with deep hostility and frustration feelings.
6. Differential patterns are noted in intelligence examinations and Rorschach protocols.

#94 -- We probably follow Cleckley more closely than anyone else, but the meaning, limits, and applicability of the term vary somewhat with each clinician.

Not giving definition or description -- #10, 12, 13, 19, 28, 41, 44, 52, 59, 63, 64, 69, 83, 88, 89, 90, 92, 95

Answers from Psychiatrists Attached to Correctional Institutions

Similar term used:

Character neurotic -- #1
Psychopathic personality -- #24
Constitutional psychopath -- #29 & 30

Definition or description:

#1 -- Descriptively -- I use it for those rare cases that show life-long traits of egocentricity, emotionality we connote infantile, absence of consistent goal performance, failure at achieving interpersonal security, defective utilization of experience for future behavior.

Dynamically -- it includes individuals whose burden of hostility necessitates their creating and assuming similar affective feeling by others -- their projected aggressiveness is resolved in behavior, not merely in the symbolic solution of the neurotic or psychotic. The so-called pervert may be psychopathic -- he may not.

APPENDIX E-8

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

#2 -- (1) Emotional immaturity (2) Egocentricity (3) Narcissism (4) Impulsiveness (5) Defective judgment (6) Omnipotence (7) Playing with life.

#3 -- Psychopathic behavior in the very recent past plus a history of emotional instability and psychopathic and neurotic reaction patterns dating back to earliest childhood.

#4 -- (1) Emotional instability from an early age; manifested by temper tantrums, truancy, failure to get along with playmates, thieving, lying.
(2) Tendency toward impulsive action.
(3) Unsatisfactory employment history.
(4) Strong migratory tendencies.
(5) Egocentricity, with ideas of self-importance.
(6) Unwillingness to accept responsibility for misdeeds.
(7) Lack of fixity of purpose.
(8) Tendency to discount the future heavily in terms of the present.
(9) Failure to learn from experience
(10) Unsatisfactory adaptation to any environment.
(11) Lack of insight as to inability to carry out good intentions.
(12) Resentment of supervision.
(13) Possession of few desirable friends.
(14) Symptomatology more marked when subject is under 30 years of age.

#5 -- An individual who fundamentally differs from his fellows of like race and status and one who cannot discern differences and lacks judgment tending to promote proper social behavior.

#6 -- That given by the Committee on Statistics of the American Psychiatric Association in the Statistical Manual for the use of hospitals for mental diseases.

#7 -- Anyone showing psychotic or psychoneurotic tendencies or potentialities to a degree that institutional care has been sought. This is not a definition but does cover our needs at this school of 1900 inmates.

#8 -- An individual who has exhibited adjustment difficulties over a long period of time and who continues to display difficulty in getting along, who does not seem to profit by past experience, and who may be subject to episodic emotional outbursts. Occupational adjustment generally characterized by frequent job changes.

APPENDIX E-8

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

#9 -- If a good history can be obtained, the psychopath will show abnormal behavior from earliest years. The psychoneurotic dates from a given event or trauma or setup; the psychotic, of course, shows deeper psychic damage often with hallucinations and delusions or severe emotional disturbances of the nature that require segregation (unable to compromise the situation in the manner a psychoneurotic or psychopath can). The above is very crude differentiation and is only a coarse measuring stick for beginning a deeper study of the individual. Most valuable of all is the "over-all" pattern of the individual which requires integrated data on physical, psychological development, biological, etc., fields.

#12 -- This diagnosis does not refer to a specific type but is a designation for a group of cases showing a long history of asocial behavior associated with inability to learn by experience, lack of ability to understand the rights of others, defects -- ego development, emotional instability, and immaturity, and other behavior such as alcoholism, addiction, etc.

#14 -- In my opinion a psychopath is an individual who has a poorly developed superego, has made a poor adaptation to the reality principle with adherence to the pleasure principle, has immature emotional development, lacks adult judgment and has a history of maladjustment to the school, marital and work situation.

#15 -- We regard the psychopath to be that individual whose personality presents a persistent abnormality of character and social conduct.

#22 -- None

#23 -- He makes little effort to adjust, is more unwilling than unable to do right. He possesses a distorted sense of values, acts without forethought and for personal gain only. Most of his motives are selfish. He feels insecure and is immature emotionally and childlike in his reactions. His impaired judgment is the paramount symptom complex.

#24 -- Cannot appreciate moral values, is insensitive to impressions of sympathy, cannot introject feelings of others.

#27 -- Psychiatric textbooks
Literature dealing with the criminal psychopath

APPENDIX E-8

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

#28 -- An individual subject to psychic behavior of the same type pattern who do not profit from any previous experience.

#29 -- The term is a misnomer and means nothing. The patient has symptoms for only one reason and that is for you to make a diagnosis.

#30 -- The definition of a psychopath that I use is an individual who knows the difference between right and wrong, who has the power of choice but does not avail himself of such through lack of concern and regard to the consequences.

Not giving definition or description -- #10, 11, 13, 16, 17, 18, 19, 20, 21, 25, 26

Answers from Psychologists in Correctional Institutions

Similar term used:

Social type of delinquent -- #6

Definition or description:

#1 -- Classification and diagnosis made by psychiatrist.

#2 -- For diagnostic purposes we consider a boy psychopathic when he has been a problem boy in the home, school, and community, for a number of years, and possesses the following personality traits to an extreme degree:

a. Resists or fails to profit from supervision and correction, previous court appearances, or institutionalizations.

b. Selfish, egotistical, inconsiderate, and domineering.

c. Shows bitterness and antagonism towards those who have tried to help him; unappreciative, dishonest and disloyal, even to his best friend -- a double-crosser.

d. Lacks moral conscience; lives impulsively, acts and thinks later; delights in deceiving authority; the offense is not the crime but the "getting caught;" assumes the attitude that he is "clever," officers are "dumb;" "I'll take another chance in crime."

e. Deficient in inhibitory powers. Could be compared to a new automobile with faulty brakes, or a ship without a rudder.

APPENDIX E-8

Answers from Psychologists in Correctional Institutions (cont'd.)

#3 -- Symptoms and Diagnostic Criteria of Psychopathic Personality as given by Dr. Paul William Preu in Personality and Behavior Disorders, edited by J. McV. Hunt.

#4 -- Persistence in antisocial behavior, lack of insight, shallow effect. Inability to establish loyalty to anyone.

#5 -- Unstable individual recognizing social controls but disregarding them when in conflict with the whims or desires of the moment. Intelligence usually within a normal, frequently above average range.

Behavior problems; over-sexed individuals; chronic complainers and severe malingers when there is no indication of physical cause -- ; no persistence; general inadequacy not necessarily due to lack of ability; may be regarded as psychopathic traits.

#6 -- An individual who has by inadequate early childhood training never established super ego structures. Has no inhibitions against his instinctive drives.

#7 -- A person slightly or considerably unstable and yet not psychotic or actually insane.

#8 -- Criminality, perversion, emotional conflict, neuroses.

Answers from Superintendents of Juvenile Correctional Institutions

Similar term used:

Asocial -- #2

Adolescent psychopath -- #34

Definition or description:

#2 -- Lacking capacity for affectional relationships, emotional flatness, no shame, regret, remorse and no sympathy or feeling for others.

#3 -- I am not able to judge who is and who isn't. So I aim to have the girl transferred to the Receiving Center and let Dr. _____ be the judge.

#6 -- This diagnosis is made for us by Dr. _____, School Psychiatrist.

#7 -- Maladjusted inmate characterized by emotional instability, anti-social behavior, lack of self-control.

#10 -- The child whose attitudes and actions are entirely self-centered, who shows no regard for the right of others, who completely fails to respond to appeals made on moral or ethical grounds, and who fails to profit from previous unpleasant experiences.

APPENDIX E-8

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

#11 -- Left entirely up to the diagnostic acumen and criteria of the psychiatrist. As in any other mental aberration, or physical aberration, the physician's experience must be paramount.

#13 -- Inability to face reality.
Attempts or gestures towards suicide.
Instability of attitudes.
Love of being different.
Frequent failures in family or foster placements.
Dissatisfaction with jobs and frequent changes.
Exaggerated and inflated egotism.

#15 -- The experience of the army would indicate that this is a pretty loosely used term.

#16 -- The psychopath is characterized by defect of character or personality, eccentricity, emotional instability, inadequacy, or lack of common sense, social feeling, self-control, truthfulness, energy, or persistence. Different psychopathic individuals show different combinations of these traits.

#17 -- One who is emotionally very unstable and whose personality is such that he finds difficulty in adjusting properly in various social situations.

#22 -- A psychopathic personality is defined as that type of personality that is afflicted with diminished volitional control and a heightened emotional response to stimuli.

#31 -- An emotionally unstable personality, characterized by traits of mental disease.

#32 -- There is no definitive definition as such. Deviation from the normal with suggestion of mental maladjustment as the cause of the deviation is the nearest approach to our description.

#33 -- Confirmed and continued lack of ability to assume responsibility for own acts detrimental to society.

#34 -- As we have contact with extreme aggressive behavior on the part of adolescents who have had asocial experiences on an adult level, we feel that the term "Adolescent psychopath" applies to that adolescent who is unable to reconcile his adult experience with his adolescent immaturity and as a result of same is in constant aggressive conflict with acceptable social standards.

#35 -- Various moods of extreme mental and emotional display.

#36 -- Definition given by psychiatrist.

#38 -- Emotional instability, lack of common sense, social responsiveness, self-control, etc.

APPENDIX E-8

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

Not giving definition or description -- #1, 4, 5, 8, 9, 12, 14, 18, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 37

Answers from Superintendents of Adult Correctional Institutions

Similar term used:
Psychopathic personality -- #17

Definition or description:

#1 -- The chronic abnormal social and mental reactions to the ordinary conditions of life on the part of one who cannot be classified in any of the groups of the insanities, neuroses, or mental defectives.

#2 -- Our own "home-made" definition might be "a psychopath is an individual whose emotions and mentalities are not normally perceptive and reactive."

#4 -- Acute cases are, of course, transferred to the State Hospital. Those upon their return and others in this class are defined as unstable, emotional, difficult to adjust to any group or any employment and subject to unreasonable outbursts of temper.

#5 -- Standard APA nomenclature and terminology.

#6 -- When a person's reactions are markedly different from his normal reaction to his surroundings.

#7 -- General lack of mental stability.

#9 -- No arbitrary definition of a psychopath. Diagnosis is based on behavior in prison.

#10 -- One who is irresponsible, unadjustable. One who usually loves to make trouble and who is intelligent enough to succeed in this undertaking. It would seem that there should be special treatment for this group and that they should not be committed to those institutions where other types of offenders are incarcerated. One is enough to take all the joy out of working with the group.

#11 -- A person who is emotionally unstable to such an extent that she has become sexually promiscuous, an alcoholic, or is in other ways unable to adjust to a socially acceptable life.

#12 -- A person who exhibits signs of suffering from a mental disease.

#13 -- Failure to adapt, brooding habits, extreme nervousness, unusual irritability, etc.

APPENDIX E-8

Answers from Superintendents of Adult Correctional Institutions (cont'd.)

#14 -- Diagnosis of psychopath is made by doctors from the _____ State Hospital. This is not done by our medical staff.
#15 -- Emotional instability and sexual abnormality. Personality deviations. Neurological, plus history of the inmate.
#16 -- Turned over to the State Hospital for diagnosis.
#17 -- The psychiatrist makes the diagnosis - not the institution.
#19 -- Transferred to State Hospital for treatment.
#27 -- I have often wondered what guides the psychologists and psychiatrists use in determining this classification, because I often differ with their diagnosis, particularly after knowing the man in the institutions over a number of years.

Not giving definition or description -- #3, 8, 18, 20, 21, 22, 23, 24, 25, 26

Answers from State Departments of Welfare

Similar term used:
Psychopathic personality -- #4
Psychoneurotic -- #7
Individuated boy and/or psychopathic -- #12
Social maladjustment or mental defective or emotional immaturity -- #21
Asocial delinquent -- #33

Definition or description:
#1 -- This definition should be left to a psychiatrist.
#5 -- We are guided entirely by the diagnosis of the psychiatrist to whom the child has been referred. We have been given no general definition, as we make use of a number of different psychiatrists.
#8 -- The one generally used by American Psychiatric Association.
#12 -- There are various types of psychopathy -- there being both qualitative as well as quantitative differences. In general, however, the psychopath reacts at an infantile emotional level, demanding immediate satisfactions, not being able to form positive emotional contacts, quite impulsive and egocentric. There is no single description which can be given.
#18 -- We do not diagnose.

APPENDIX E-8

Answers from State Departments of Welfare (cont'd.)

#18 -- We do not have a legal definition of psychopath. We resort to the psychiatric terms as found in the Psychiatric Word Dictionary.
#23 -- We would usually ask a psychiatrist to give us a definition of his diagnosis since it has been my impression that the term "psychopath" is a catch-all for many forms of mental and emotional disability.
#31 -- "shallow emotional level," "lack of regard for consequences," "repetition of patterns leading to frustration."

Not giving definition or description -- #2, 3, 4, 6, 7, 9, 10, 11, 14, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 32, 33

Answers from Independent Juvenile Courts

Similar term used:
Psychopathic personality -- #10 & 15
C.P.I.-E.I. -- #11
More individually descriptive terms, such as neurotic, psychoneurotic, psychotic, immature, narcissistic, schizophrenic, manic-depressive, emotionally disturbed, etc. -- #16

Definition or description:
#1 -- Can't answer.
#3 -- This is a matter for the psychiatrists to decide -- cannot answer.
#4 -- This is left to the psychiatrist.
#5 -- Egocentric, selfish, willful person with little sense of responsibility for others.
#7 -- We cannot concieve of a _____ [illegible].
#10 -- A psychopath is a type of individual who has an inadequate development of the superego system, at least inadequate for the control of the powerful instinctive drives. Childish standards of conduct are not replaced by social ideas in the course of development.
#11 -- A child who has an appealing manner, an answer to every inquiry, an excuse for every transgression, a promise filled with copious tears, and a uniformly irregular history of difficulty with everybody and everything which fails to meet his concepts of what should be. Other factors such as enuresis, nail biting, excessive dreaming, irregularity of habits, etc., etc.

APPENDIX E-8

Answers from Independent Juvenile Courts (cont'd.)

#14 -- Chronic truancy, anti-social behavior, temper tantrums, etc.
#15 -- We depend on diagnosis of psychiatrist.

Not giving definition or description -- #2, 6, 8, 9, 12, 13, 16

Answers from Combined Juvenile Courts

Similar term used:
Psychotic -- #4
Character disorder -- #14
Mental case -- #16

Definition or description:
#2 -- Abnormal nervous and mental reaction and inability to adjust himself to normal human relations.
#5 -- "one characterized by extreme susceptibility to fears, doubts and has hallucinatory ideas that are becoming fixations." One with inferiority complexes.
#6 -- If we feel that the child's irresponsibility is due to mental unsoundness we determine the course to follow solely by what is best for the welfare of the child. Normally institutional care is needed where the child has been referred to the court. Occasionally we can make foster-home placements where conditions in the home are favorable.
#7 -- A person other than drunkard, epileptic, feebleminded, who is in need of treatment for his own good or the good of society. In Minnesota we have opposed "static," "settled" technical statutory definitions.
#8 -- An examination by a competent psychiatrist in which a diagnosis of psychopathy is rendered would be accepted as evidence.
#9 -- Mentally ill.
#14 -- Usually "catch all" phrase for those who have not developed abilities at self-control and which cannot be explained under other classifications. In juvenile proceedings, the necessity of clear-cut diagnosis is not necessary. Recommendations in planning more important from judges' viewpoint.
#16 -- Am guided by opinion of physician.

Not giving definition or description -- #1, 3, 4, 10, 11, 12, 13, 15

APPENDIX E-8

Answers from Circuit Court Level

Similar term used:
- Either alcoholic or insane -- #11
- Insane person or mental defective -- #14
- Mental incompetent -- #37
- Sane or insane -- #44

Definition or description:
- #1 -- The term "psychopathic personality" as used in this court means the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons.
- #3 -- Mental and nervous disorder which produces social instability.
- #6 -- Left to court physicians.
- #8 -- Lunacy.
- #10 -- One who suffers from hallucinations, abnormal fears, or perhaps a very severe inferiority complex is, I think, a psychopath.
- #11 -- None
- #12 -- Depend on physician.
- #14 -- Any person who is mentally defective.
- #19 -- Illinois Revised Statutes, Sec. 820, Chapter 38.
- #21 -- We place responsibility on psychiatrist. Is it safe to allow the respondent to mingle freely in society?
- #27 -- Statutory definition of insanity.
- #43 -- This court is guided by the recommendations of two physicians appointed for the examination.
- #44 -- The question is always whether he is suffering from a diseased mind which causes him not to know right from wrong, or if he does know, he cannot resist doing wrong, and that his inability to resist is caused solely by the disease of his mind.

Not giving definition or description -- #2, 4, 5, 7, 9, 13, 15, 16, 17, 18, 20, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

Answers from Magistrate Court Level

Similar term used:
- Incompetent -- #18

APPENDIX E-8

Answers from Magistrate Court Level
(cont'd.)

Definition or description:
#1 -- One who can't keep out of trouble -- et cetera.
#4 -- I have none. Each case on its own merits.
#6 -- Haven't used any thus far.

Not giving definition or description -- #2, 3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19

APPENDIX E-9

DISTRIBUTION OF PSYCHOPATHY THROUGH LEVELS OF INTELLIGENCE

Question: Do you consider psychopathy to be distributed
a. Through higher levels of intelligence?
b. Through middle levels of intelligence?
c. Through lower levels of intelligence?

Answers from Psychiatrists in State Mental Hospitals

a -- #1, 2, 4, 5, 6, 7, 8, 9, 12, 13, 15, 16, 17, 18, 20, 21, 22, 23, 25, 27, 28, 30, 31, 33, 34, 37, 38, 40, 45, 48, 50, 51, 52, 54, 55, 56, 59, 60, 61, 62, 63, 64, 67, 68, 70, 73, 74, 75, 76, 77, 78, 80, 81, 82, 83, 84, 86, 87, 91, 92, 93, 94, 95

b -- #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 20, 21, 22, 25, 26, 27, 30, 31, 32, 33, 34, 37, 38, 40, 42, 44, 45, 47, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 66, 67, 68, 70, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 86, 87, 91, 92, 93, 94, 95

c -- #1, 4, 5, 6, 8, 9, 12, 13, 15, 19, 20, 21, 22, 25, 27, 30, 33, 34, 37, 38, 40, 42, 49, 50, 51, 59, 61, 62, 63, 67, 68, 73, 74, 75, 77, 78, 81, 82, 84, 85, 86, 87, 91, 93, 95

Comments or qualifications:
"Independent of intelligence" (#35)
"No correlation with intelligence" (#36)
"Has very little to do with it" (48)

Not answering this question -- #24, 29, 39, 41, 42, 65, 69, 71, 88, 89, 90

Answers from Psychiatrists Attached to Correctional Institutions

a -- #1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 14, 28, 29, 30

b -- #1, 2, 3, 5, 6, 7, 10, 11, 12, 13, 15, 28, 30

c -- #1, 2, 3, 5, 6, 7, 10, 11, 12, 13, 15, 28

Not answering this question -- #8, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

APPENDIX E-10

DEGREES OF PSYCHOPATHY

Question: Do you consider that there are degrees of psychopathy (as, for example, there are degrees of feeblemindedness)?
a. Yes
b. No

Answers from Psychiatrists in State Mental Hospitals

Answering "No" -- #8, 68, 71, 81, 85
Not answering this question -- #12, 29, 41, 69, 88, 89, 90
All others answered "Yes."
Comments or qualifications:
#8 -- "Some are more difficult than others, etc."
#31 -- "There may be but not in the sense that it would be practical to designate a psychopathic of this or that degree. Absence of any standard."
#65 -- "Possibly yes, but we do not know any unit by which these degrees can be measured."

Answers from Psychiatrists Attached to Correctional Institutions

Answering "No" -- #29
Not answering this question -- #16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27
All others answered "Yes."

APPENDIX E-11

NEED FOR BETTER CLARIFICATION OF THE CONCEPT

Question: Do you consider that there is need for a better clarification of the psychopathic concept?
a. Yes
b. No

Answers from Psychiatrists in State Mental Hospitals

Answering "No" -- #8, 17, 38, 42, 52, 53
Not answering this question -- #24, 29, 41, 58, 69, 88, 89, 90
All others answered "Yes."
Comments or qualifications:
#47 -- "By all means yes. Statistical Manual of National Committee for Mental Hygiene used for diagnosis, but wholly inadequate."
#56 -- "Probably among laymen and prison officials."
#74 -- "Certainly. A need for a better legal standard of criminal responsibility also."
#87 -- "Legal concepts should be altered. At present we have no adequate legal code for dealing with these people."

Answers from Psychiatrists Attached to Correctional Institutions

Not answering this question -- #1, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27
All others answered "Yes."

APPENDIX E-12

ETIOLOGICAL FORMULATIONS

Question: What is your opinion as to the etiology of the psychopath?

a. Unknown
b. Congenital
c. Inheritance
d. Physical disease (Please specify what kind)
e. Some kind of psychic trauma in childhood
f. Other etiological factors (Please specify)

Answers from Psychiatrists in State Mental Hospitals

a -- #1, 2, 4, 6, 10, 11, 17, 25, 28, 33, 36, 39, 42, 45, 47, 49, 55, 58, 60, 65, 73, 74, 78, 81, 82, 83, 84, 85, 86, 91, 92, 94

b -- #4, 5, 9, 15, 21, 22, 24, 25, 31, 36, 50, 53, 56, 66, 72, 74, 75, 76, 80, 91

c -- #4, 5, 12, 13, 14, 15, 18, 19, 20, 27, 33, 34, 36, 37, 38, 40, 43, 44, 51, 52, 53, 54, 56, 59, 62, 63, 64, 67, 68, 70, 77, 79, 82, 91

d -- #4, 5, 18, 36, 40, 61, 67, 82
Kind of disease -- Any affecting nervous system (#40). Encephalitis (#61). Encephalitis lethargica of children (#67). Encephalitis lethargica (#82)

e -- #4, 7, 9, 14, 18, 20, 22, 26, 27, 32, 33, 34, 35, 36, 40, 43, 46, 47, 57, 61, 62, 68, 74, 77, 78, 93

f:

#1 -- Constitutional
#3 -- Constitutional defect
#8 -- Probably a developmental disorder
#12 -- Early environment
#13 -- Early environment
#14 -- Early training and emotional stunting
#15 -- Head trauma at birth or injury at early age
#16 -- Faulty training
#18 -- Factors creating a condition of inferiority
#20 -- Parents who pet, pamper, spoil and indulge their children. Broken, disorganized homes. Children who have not had a fair share of love and affection.
#27 -- Constitutional
#30 -- Early environment
#32 -- Improper handling by parents
#36 -- Bad environment and bad conditioning
#37 -- Environment and training
#40
#48 -- Lack of cerebral centers or allular nuclei or hormone activity to activate them

APPENDIX E-12

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

f (cont'd.):
#50 -- Conditioned reflex reactions
#54 -- Broken homes, poor childhood environment, poor childhood training, over-indulgent parents, and too rigid and early discipline.
#57 -- Constitutional predisposition
#59
#71 -- Environment, too great stress and strain
#74 -- Paternal overprotection
#86 -- Defective training in childhood and adolescence
#87 -- Faulty early training
#93 -- Poor relationship of parent to child, a functional handicap that discourages efforts for success.
#94 -- Psychogenic and social environment in some. Inborn, Constitutional abnormality in some.
Not answering this question -- #29, 41, 69, 88, 89, 90, 95

Answers from Psychiatrists Attached to Correctional Institutions

a -- #4, 6, 8, 10, 11, 12, 29
b -- #9, 12, 29, 30
c -- #2, 5, 11, 15, 29
d -- #1, 12, 29
Kind of disease -- Encephalitis (#1). Organic brain disease (#12)
e -- #1, 2, 3, 4, 5, 13, 14, 28, 29
f:
#1 -- Head injury; impersonal and abstract care during first two years; absence of parental identifications; neurotic engendering experiences in infancy reenforced by developmental experience.
#7 -- Perhaps any one or more of these
#12 -- Early training
#14 -- Absence of either or both parents, adverse parental attitudes; prolonged, painful, or cripoling illness in childhood.
#30 -- Accentuated under environmental factors
Not answering this question -- #16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

APPENDIX E-13

CATEGORIES MOST CLOSELY RELATED TO AND MOST LIKELY TO BE CONFUSED WITH PSYCHOPATHY

Question: To what other category do you consider the psychopath most closely related?
a. Psychotics
b. Psychoneurotics
c. Feebleminded
d. Any other (Please specify)

With what other category do you think the psychopath is most likely to be confused?
a. By professional workers _____
b. By laymen _____

Answers from Psychiatrists in State Mental Hospitals

Most closely related to psychotics -- #4, 6, 7, 8, 9, 16, 17, 19, 20, 31, 35, 37, 39, 40, 43, 44, 47, 66, 67, 72, 74, 82, 91

Most closely related to psychoneurotics -- #1, 2, 4, 5, 7, 8, 10, 11, 13, 14, 21, 22, 23, 24, 27, 30, 32, 33, 34, 35, 36, 40, 42, 45, 46, 48, 49, 54, 58, 59, 60, 61, 62, 67, 68, 71, 73, 80, 83, 84, 85, 87, 93, 94, 95

Most closely related to feebleminded -- #4, 15, 18, 25, 26, 38, 40, 51, 53, 57, 63, 65, 72, 76, 77, 79, 80

Most closely related to any other -- Mentally sub-normal (#21). Schizophrenia - early (#48). Emotional immaturity (#50). Borderline psychotics (#55). Constitutional life-long incurable offenders (#56). Maladjustments due to defective home direction (#86)

Not answering this portion of question -- #12, 28, 29, 41, 52, 64, 69, 73, 81, 88, 89, 90, 92

Categories with which confused by professional workers:
- Psychotics (#2, 19, 25, 31, 32, 37, 39, 46, 53, 63, 72, 74, 76, 80, 95)
- Psychoneurotics (#3, 5, 11, 13, 14, 26, 27, 49, 57, 62, 83, 86, 87, 92)
- Schizophrenia (#6, 17, 20, 94)
- Criminals (#36, 47, 77)
- Psychotics or psychoneurotics (#67, 91)
- Feebleminded (#22, 71)
- Psychiatric (#7)
- Schizophrene simplex (#9)
- Simple schizophrenia and psychoneurotic (#12)
- Mental deficiency and dementia praecox (#15)
- Criminals, alcoholics, manics (#33)
- Neurotics and criminals (#35)
- Homosexual (#38)

APPENDIX F-13

Answers from Psychiatrists in State Mental Hospitals
(cont'd.)

Categories with which confused by professional workers (cont'd.):
- Paranoid praecox (#42)
- Psychotics and alcoholics (#45)
- Mental deficients and psychoneurotics (#48)
- Dementia praecox and manic-depressive (#51)
- Psychosis with mental deficiency (#54)
- An onery and cussed individual (#55)
- Incipient dementia praecox (#56)
- Behavior problems (#59)
- Schizoids (#66)
- Normal (#75)
- Praecox and neurotic (#78)
- Oligophrenia and psychotic (#82)
- Dementia praecox simple type (#85)
- Psychoneurotics, alcoholics, and drug addicts (#93)

Not answering this portion of question -- #1, 4, 8, 10, 16, 18, 21, 23, 24, 28, 29, 30, 34, 40, 41, 43, 44, 50, 52, 58, 60, 61, 64, 65, 68, 69, 70, 73, 79, 81, 84, 88, 89, 90

Categories with which confused by laymen:
- Psychotic (#5, 11, 14, 19, 24, 25, 27, 30, 36, 39, 46, 47, 57, 60, 61, 62, 64, 71, 72, 74, 75, 76, 80, 91, 95)
- Criminals (#2, 3, 7, 21, 22, 26, 33, 37, 49, 59, 68, 86)
- Normal (#13, 63, 78)
- Mental deficiency (#15, 38, 45)
- Feebleminded (#32, 53, 54)
- Criminals and malingerers (#9)
- Criminals (bad boy) (#12)
- Martyr (#16)
- Nervousness (#17)
- "Ne'er do wells" (#20)
- Criminals or psychotics (#31)
- Criminals, "normals," perverts (#35)
- Alcoholics and criminals (#48)
- Insanity (#51)
- An ornery and cussed individual (#55)
- Psychotic and feebleminded (#65)
- Feebleminded or psychoneurotic (#70)
- Defective delinquent (#77)
- Criminals and sex maniacs (#85)
- Eccentrics and maladjusted (#92)
- Criminals and psychoneurotics (#95)

APPENDIX E-13

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Not answering this portion of question -- #1, 4, 6, 3, 10, 18, 23, 28, 29, 34, 40, 41, 42, 43, 44, 50, 52, 56, 59, 66, 67, 69, 73, 79, 81, 82, 83, 84, 87, 88, 89, 90, 94

Answers from Psychiatrists Attached to Correctional Institutions

Most closely related to psychotics -- #10, 11, 13
Most closely related to psychoneurotics -- #2, 3, 9, 11, 14, 28, 29
Most closely related to feebleminded -- #12, 13, 15
Most closely related to any other -- Post-encephalitic syndrome (#4). Normal individual (#6). A cross between feeble-minded and psychotic (#13). Defective delinquent (#15 and 21). Dementia praecox simplex type (#30)
Not answering this portion of question -- #1, 5, 7, 8, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27
Categories with which confused by professional workers:
- Psychotics (#3, 4)
- Psychoneurotics (#9, 28)
- Long standing neurotic maladjustment (#1)
- Paranoid personalities (#2)
- Inferiors (lack of judgment) (#5)
- Dementia praecox (#6)
- "Spoiled" (#7)
- Psychoneurotics or psychotics (#14)
- Feebleminded (#15)

Not answering this portion of question -- #8, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30
Categories with which confused by laymen:
- Psychotics (#3, 5, 6, 9, 14)
- The repeated offender (#1)
- Malingerers (#2)
- Feebleminded (#4)
- "Just plain bad" (#7)
- Deliberate criminal (#12)
- The delinquent (15)
- Insane or criminal or both (#28)

Not answering this portion of question -- #8, 10, 11, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30

APPENDIX E-14

DISPOSITION OF THE PSYCHOPATHIC OFFENDER BY WELFARE AGENCIES AND COURTS

Question: If a person is diagnosed as a psychopath prior to commitment (or sentence), is he always or sometimes (underline "always" or "sometimes" depending upon procedure followed) sent to the following kinds of institutions?

a. General prison
b. An institution for the insane
c. An institution for the criminal insane
d. Other disposition (Please specify what kind of other disposition)

Answers from State Departments of Welfare

Always a -- None
Always b -- None
Always c -- None
Always d -- Boys vocational school (#12)
Sometimes a -- #2, 23
Sometimes b -- #2, 5, 7, 8, 13, 15, 16, 23
Sometimes c -- #2, 16
Sometimes d:
- Foster home care or employment (#2)
- State training school, Home School for Girls, Home of Good Shepherd, special foster homes (#5)
- Training school, reformatory, vocation schools with disciplinary programs (#7)
- Industrial school (#8)
- State training school or reformatory; institution for feebleminded if mentally retarded (#10)
- Training school (#13)
- Foster care or industrial school (#15)
- Study home, state training schools (#23)

Comments or qualifications:
- #4 -- "Disposition depends upon total picture of the case."
- #7 -- "The services availabel to them are definitely limited and usually they remain at large doing as they wish or are later confined in prison."

Not answering this question -- #1, 3, 6, 9, 11, 14, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33

APPENDIX E-14

Answers from Independent Juvenile Courts

Always a -- None
Always b -- None
Always c -- None
Always d -- None
Sometimes a -- None
Sometimes b -- #1, 7, 10, 11, 12, 16
Sometimes c -- #12, 16
Sometimes d:
- Industrial school (#1)
- Placement by parents in specialized institutions with psychiatric programs (#3)
- Training school (#7)
- Correctional institution: treatment in our psychiatric treatment clinic (#10)
- Detention home; juvenile correctional institutions (#11)
- Hospital other than state hospital (#12)
- Referred to mental clinic or suitable institution (#15)
- Vocational school, training school, other schools, boarding homes, committment to other agencies for supervision or placement, remain in own home with continued psychiatric supervision (#16)

Not answering this question -- #2, 4, 5, 6, 8, 9, 13, 14

Answers from Combined Juvenile Courts

Always a -- None
Always b -- #6, 7, 8
Always c -- None
Always d:
- We muddle along trying to work out something with their families, friends, etc. (#4)
- Receiving home for children, industrial schools (#5)
- Boys home or reformatory (#9)

Sometimes a -- None
Sometimes b -- #3, 14
Sometimes c -- None
Sometimes d:
- Industrial school (#2)
- Correctional institutions for children (#3)
- Home for feebleminded. Also, special institution for special care (#16)

Not answering this question -- #1, 10, 11, 12, 13, 15

APPENDIX E-14

Answers from Circuit Court Level

Always a -- None
Always b -- #3, 8, 12, 13, 14, 16, 31, 43, 44
Always c -- #1, 2, 6, 17, 19
Always d -- None
Sometimes a -- #10, 27 (ward for criminally insane)
Sometimes b -- #21, 22 (only if adjudged insane), 27, 37
Sometimes c -- #21
Sometimes d:
  Released on probation in care of some qualified person (#10)
  Referred to governor in capital cases (#21)
Not answering this question -- #4, 5, 7, 9, 11, 15, 18, 20, 23, 24, 25, 26, 28, 29, 30, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42

Answers from Magistrate Court Level

Always a -- None
Always b -- #4, 10
Always c -- #15
Always d -- None
Sometimes a -- #1
Sometimes b -- #7
Sometimes c -- None
Sometimes d -- Care of relative (#1)
Not answering this question -- #2, 3, 5, 6, 8, 9, 11, 12, 13, 14, 16, 17, 18, 19

APPENDIX E-15

THE HANDLING OF THE PSYCHOPATH IN STATE MENTAL HOSPITALS AND CORRECTIONAL INSTITUTIONS

Question: How are the psychopaths being handled in your institution?
a. The same as other patients (or inmates)
b. In a way different from other patients (or inmates)
(Please describe difference, if any)

Answers from Psychiatrists in State Mental Hospitals

a -- #1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 30, 31, 32, 33, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, 49, 50, 51, 52, 53, 54, 56, 57, 58, 59, 60, 61, 62, 64, 65, 66, 67, 68, 70, 71, 72, 73, 74, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 91, 92, 93, 94

b:

#9 -- Usually are given ground privileges. Are often given work entailing some responsibility. Each individual case is different of course. Their treatment is therefore individualized.

#16 -- Received treatment suitable for a psychopathic personality appealing to the emotion rather than the intellect.

#34 -- Less restricted

#48 -- Usually given more liberty and responsibility. Always placed in the best quarters and convalescent wards.

#55 -- Closer supervision; no ground parole privileges, etc.

#75 -- Locked ward housing and close supervision about the ground

#95 -- Not detained unless psychotic or when no longer psychotic

Comments and qualifications:

#8 -- "These cases no different because they don't relish restraint"

#23 -- Those with psychosis treated same as others. Psychopathic without psychosis dismissed."

#28 -- "Many times psychopath handles us and requires far more daily supervision than the average psychotic person."

#36 -- "i.e., each case is individualized, whether a psychopath or other diagnosis."

#40 -- With attention to their special needs"

APPENDIX E-15

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

#63 -- "Patients who have a psychopathic personality and do not have a psychosis must necessarily be discharged as soon as the diagnosis is made as they are not considered to be insane."

Not answering this question -- #29, 41, 69, 88, 89, 90

Answers from Psychiatrists Attached to Correctional Institutions

a -- #1, 2, 5, 7, 8, 11, 13, 14, 22, 23, 25, 26, 27, 29

b:

#3 -- The trouble psychopaths segregated in another building

#4 -- Segregated until they show improvement after having become involved in difficulties

#6 -- Segregation

#9 -- Segregated in observation quarters in hospital during upsets. Ambulatory cases seen by clinic at other times

#10 -- In custodial building with difficult patients

#12 -- More closely supervised and treated

#24 -- Psychiatric advice; in serious instances segregated

#28 -- Frequent personal interviews. Occupational therapy instead of work units; music. Individual room to sleep in. Quiet cottage life when possible. Isolation during prodromata; outbursts sometimes avoided in this way. Increased understanding on the part of other inmates through council study

#30 -- Segregated, if a behavior problem

Comments or qualifications:

#5 -- "No facilities have yet been developed. We hope for building with security features where they can be segregated."

#7 -- "Mostly"

#14 -- "With the exception of the passive homosexual psychopath, who is sent to the Medical Center for Federal Prisoners at Springfield, Missouri."

#25 -- "Some slight recognition of the classification committee"

#27 -- "Some extreme cases transferred to the Medical Center for Federal Prisoners"

Not answering this question -- #15, 16, 17, 18, 19, 20, 21

APPENDIX E-15

Answers from Psychologists in Correctional Institutions

a -- #1, 2, 3, 5, 6
b:
- #4 -- More frequent interviews
- #7 -- Slightly different through cell placing, work assignment, occasional interviews and such psychotherapy as can be provided for the more pressing cases
- #8 -- Some receive special therapy

Comments or qualifications:
- #2 -- "Extreme cases are referred to psychologist for individual attention: mental hygiene or transfer to another type of institution."
- #5 -- "Occasional psychiatric treatment"

Answers from Superintendents of Juvenile Correctional Institutions

a -- #3, 7, 8, 9, 10, 11, 12, 14, 17, 18, 19, 23, 34, 37
b:
- #1 -- Medication program and special counseling by the psychiatrist
- #2 -- More attention from clinic
- #6 -- Special attention given to work, school and home assignments and seen regularly by school psychiatrist
- #13 -- Behavior necessitates much more personal attention and adjustment
- #15 -- Frequent conferences. Careful study of background. Special assignments
- #16 -- We follow the directions of a psychiatrist
- #22 -- Further study with some type of therapy for cases needing such treatment
- #31 -- Individually
- #32 -- Kept in segregation at night
- #33 -- Individual programs and counselling

Comments and qualifications:
- #7 -- "Extreme cases hospitalized"
- #9 -- "Except that allowance is made in their particular case. In extreme cases, we try to send them to a clinic."
- #11 -- "Practically"
- #14 -- "Individual attention where possible"
- #23 -- "Our psychopaths live along with the other boys, and receive about the usual type of treatment for normal boys."

APPENDIX E-15

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

#34 -- "But give much more intensive supervision"
#36 -- "Not kept in this institution"
#37 -- "To all appearances, but provide special training, guidance, and out-patient clinical services"
#38 -- "Have none at this time"

Not answering this question -- #4, 5, 20, 21, 24, 25, 26, 27, 28, 29, 30, 35

Answers from Superintendents of Adult Correctional Institutions

a -- #1, 3, 4, 7, 8, 10, 11, 12, 13, 14, 16, 17, 27

b:

#2 -- Special consideration of placement, employment program, and individual treatment
#5 -- Segregation in special ward of hospital; arrangements now being made for treatment by physicians of state medical school
#6 -- Isolation room in hospital
#9 -- If condition is serious enough to warrant, he is transferred to state hospital
#15 -- Handled on individual basis according to indications in each case
#23 -- Given closer medical supervision and every possible chance to correct their condition.

Comments and qualifications:

#13 -- "Except severe cases"
#27 -- "Extreme cases are given special treatment."

Not answering this question -- #18, 19, 20, 21, 22, 24, 25, 26

APPENDIX E-16

EXTENT OF SEGREGATION OF PSYCHOPATHS WITHIN STATE MENTAL HOSPITALS AND CORRECTIONAL INSTITUTIONS

Question: In your institution to what extent are psychopaths segregated from other patients (or inmates)?

a. Not at all
b. Separate building
c. Separate wing of building
d. Separate floor
e. Any other type of segregation (please specify what kind)

Answers from Psychiatrists in State Mental Hospitals

a -- #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 31, 33, 35, 36, 37, 38, 39, 42, 43, 44, 45, 46, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 70, 71, 72, 73, 74, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 91, 92, 93, 94

b -- #32, 49, 75

c -- #34, 47, 87

d -- None

e:

#9 -- None except as their occupation necessitates
#28 -- When necessary because of problems of the individuals in the hospital group
#33 -- According to their adjustment on the wards
#40 -- According to the requirements of the individual case
#48 -- With convalescent patients
#95 -- Subject to psychiatric classification

Comments or qualifications:

#1 -- "Except that many are in criminal insane building"
#36 -- "Patients are segregated according to behavior, social integration, and hospital adjustment, not according to diagnosis"
#57 -- "I feel they should be."
#72 -- "Only psychopaths with psychosis are treated as in-patients and no separate wards are provided for psychopathic persons with psychosis as distinguished from other psychotics."
#74 -- "Because of crowded conditions it is not possible to segregate these patients."

Not answering this question -- #29, 41, 69, 88, 89, 90

APPENDIX E-16

Answers from Psychiatrists Attached to Correctional Institutions

a -- #1, 5, 8, 11, 12, 13, 14, 22, 23, 25, 26, 29
b -- #3, 6, 24
c -- #2
d -- #2, 4
e:
#7 -- Separate rooms for about half of them when needed
#9 -- Segregation in observation quarters in hospital during upsets
#10 -- With other difficult patients
#27 -- Only extreme cases who fail to adjust are segregated
#28 -- Allowed to go to own room when disturbed. Frequently hospitalized
#30 -- Segregated if behavior problem
Comments or qualifications:
#2 -- "Only when behavior requires more supervision"
#4 -- "Only when they get in trouble"
Not answering this question -- #15, 16, 17, 18, 19, 20, 21

Answers from Psychologists in Correctional Institutions

a -- #1, 2, 3, 4, 5, 6
b -- None
c -- None
d -- None
e:
#7 -- Primarily through cell assignment. Careful selection of cell mates
#8 -- Worst cases are segregated, sometimes at own request

Answers from Superintendents of Juvenile Correctional Institutions

a -- #1, 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 17, 18, 19, 22, 23, 32, 33, 34, 37, 38
b -- None
c -- #31
d -- None
e:
#15 -- Separate school classification and classes

APPENDIX E-16

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

#37 -- Foster home plan, within institution or community

Comments or qualifications:

#6 -- "Sometimes sent to infirmary when medical care and change of environment seem advisable"

#7 -- "Difficult cases are placed in the hospital for observation and care"

#9 -- "Except in extreme cases"

#16 -- "Depends entirely upon the directions of a psychiatrist"

#32 -- "Except kept in segregation at night"

Not answering this question -- #4, 5, 20, 21, 24, 25, 26, 27, 28, 29, 30, 35, 36

Answers from Superintendents of Adult Correctional Institutions

a -- #1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 23, 27

b -- None

c -- None

d -- #5

e:

#6 -- Isolation room in hospital

#15 -- Sexual psychopaths placed where they are under close personal supervision -- frequently work in laundry

Comments or qualifications:

#2 -- "Unless disturbing. Hospital for cases needing restraint or care"

#4 -- "Isolation when in disturbed state"

#9 -- "Providing case is mild. Occasionally they are locked in their cells"

#10 -- "No facilities for segregation except by isolation in the control cells. Only used when everything else has failed in way of adjustment to the group"

#13 -- "Except severe cases"

#14 -- "Except rational cases and they are segregated"

#27 -- "Other than extreme cases"

Not answering this question -- #18, 19, 20, 21, 22, 24, 25, 26

APPENDIX E-17

THE PSYCHOPATH AS A PROBATION AND PAROLE RISK

Question: Do you think the psychopath is a good probation risk?
a. Yes
b. No
Do you think the psychopath a good parole risk?
a. Yes
b. No

N.B. Psychiatrists and state departments of welfare were asked both of the above questions. The courts were asked about probation only, while correctional institutions were asked about parole only.

Answers from Psychiatrists in State Mental Hospitals

Good probation risk -- #30, 44, 47, 48, 57, 71, 95
Not good probation risk -- #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, 32, 33, 36, 38, 39, 43, 46, 49, 50, 51, 52, 53, 54, 55, 56, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 70, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 91, 92, 93, 94
Comments or qualifications:
#26 -- "There are great individual differences."
#34 -- "Individual problem"
#35 -- "Depends on individual cases"
#37 -- "Some are; some aren't"
#40 -- "Variable"
#45 -- "Depends on the individual case"
#47 -- "Depending on degree of abnormal behavior"
#48 -- "Under some circumstances but not as a general rule"
#57 -- "Under supervision"
#71 -- "Under adequate supervision and training"
#94 -- "In most instances"
#95 -- "Only fair"
Good parole risk -- #7, 16, 30, 47, 48, 57, 65, 71, 76, 95
Not good parole risk -- #1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, 32, 33, 36, 38, 39, 43, 44, 46, 49, 50, 51, 52, 53, 54, 55, 56, 58, 59, 60, 61, 62, 63, 64, 66, 67, 68, 70, 72, 73, 74, 75, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 91, 92, 93
Comments or qualifications:
#7 -- "If treatment is instituted early"

APPENDIX E-17

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Comments or qualifications (cont'd.):
- #26 -- "There are great individual differences."
- #34 -- "Individual problem"
- #35 -- "Depends on individual cases"
- #37 -- "Some are; some aren't"
- #39 -- "Except certain ones after prolonged observation"
- #40 -- "Variable"
- #47 -- "Depending on degree of abnormal behavior"
- #48 -- "Under some circumstances but not as a general rule"
- #71 -- "Under adequate supervision and training"
- #94 -- "Individual evaluation is required."

Not answering this question -- #29, 41, 42, 69, 88, 89, 90

Answers from Psychiatrists Attached to Correctional Institutions

Good probation risk -- #7

Not good probation risk -- #2, 3, 4, 5, 6, 8, 9, 11, 12, 13, 14, 15, 28, 29, 30

Comments or qualifications:
- #1 -- "An individual matter. The occasional inadequate 'C.P.I.' in a protected family situation may do well. Generally I'd guess no."
- #7 -- "If under a <u>good</u> trained or experienced supervisor as needed"
- #10 -- "Depends on case"

Good parole risk -- #2, 7

Not good parole risk -- #3, 4, 5, 6, 8, 9, 11, 12, 13, 14, 15, 22, 23, 24, 25, 26, 27, 28, 29, 30

Comments or qualifications:
- #1 -- "An individual matter. The occasional inadequate 'C.P.I.' in a protected family situation may do well. Generally I'd guess no."
- #2 -- "If he matures or demonstrates ability to adjust to an institution over a long period of time (1 to 3 yrs.)"
- #7 -- "If under a <u>good</u> trained or experienced supervisor as needed"
- #10 -- "Depends on case"
- #13 -- "I doubt seriously if a true psychopath with anti-social traits should ever be discharged from an institution. He can no more change than a leopard can change his spots or an Ethiopian his color."
- #23 -- "Never unless a sense of new values can be instilled into him through re-education"

APPENDIX E-17

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

Not answering this question -- #16, 17, 18, 19, 20, 21

Answers from Psychologists in Correctional Institutions

Good parole risk -- #8
Not a good parole risk -- #1, 2, 3, 4, 5, 6, 7
Comments or qualifications:
- #4 -- "Not after mere institutionalization without treatment"
- #7 -- "Less so than the stable person, but many stable people are still poor risks."
- #8 -- "Under certain conditions. In some cases, there seems to be a critical age followed by conformity."

Answers from Superintendents of Juvenile Correctional Institutions

Good parole risk -- #9, 15
Not good parole risk -- #1, 2, 3, 5, 6, 7, 10, 11, 13, 14, 16, 17, 18, 22, 31, 33, 34, 35, 37, 38
Comments or qualifications:
- #9 -- "Sometimes"
- #13 -- "or seldom"
- #15 -- "If properly placed"
- #37 -- "Unless parole departments are prepared to give special service in conformity with good mental hygiene practices -- cannot be handled unless workers have knowledge of techniques"
- #38 -- "Unless re-examination and close observation over a period of time shows they are safe to be out in society"

Not answering this question -- #4, 8, 12, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 32, 36

Answers from Superintendents of Adult Correctional Institutions

Good parole risk -- None
Not good parole risk -- #1, 2, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 23
Comments or qualifications:
- #2 -- "Unless he has been greatly helped during his institutionalization"

APPENDIX E-17

Answers from Superintendents of Adult Correctional Institutions (cont'd.)

Comments or qualifications (cont'd.):
- #3 -- "Depends entirely upon conditions in the home and in the community"
- #4 -- "Hard to answer because so much depends upon the family to whom she is paroled. Where patience, tact, and understanding can be assured, excellent adjustments have been made."
- #10 -- "Generally not, although that depends upon the type. I've known some who have made good on parole. They are usually intelligent, often the more intelligent of the group."
- #11 -- "We have been able to parole a few."
- #15 -- "Generally speaking
- #27 -- "Depends largely on the care of the psychologist and neuro-psychiatrist in classifying the inmate as psychopathic. Many inmates have passed through this institution that are classified psychopaths that will and have made good adjustments on parole, particularly where they have good supervision."

Not answering this question -- #5, 18, 19, 20, 21, 22, 24, 25, 26

Answers from State Departments of Welfare

Good probation risk -- #5, 15
Not good probation risk -- #2, 4, 8, 10, 12, 13, 16, 18, 33
Comments or qualifications:
- #1 -- "Depends on individual case"
- #5 -- "Under very close supervision and in communities where needed facilities are available."
- #15 -- "If proper treatment facilities are available"

Good parole risk -- #5, 15
Not good parole risk -- #2, 4, 8, 10, 12, 13, 16, 18, 33
Comments or qualifications:
- #1 -- "Depends on individual case"
- #2 -- "It is nevertheless ultimately necessary."
- #5 -- "Under very close supervision and in communities where needed facilities are available."
- #15 -- "If proper treatment facilities are available"

Not answering this question -- #3, 6, 7, 9, 11, 14, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32

APPENDIX E-17

Answers from Independent Juvenile Courts

Good probation risk -- None
Not good probation risk -- #4, 5, 6, 10, 11, 12, 14
Comments or qualifications:
- #1 -- "Can only answer in individual cases"
- #2 -- "Depending on child, parents, etc."
- #3 -- "Depends upon the recommendations of the psychiatrist and resources available to carry out recommendations"
- #7 -- "Some 'Yes,' some 'No'"
- #15 -- "Not good, but may adjust if proper treatment is available and followed"
- #16 -- "This depends on the nature and degree of the illness"

Not answering this question -- #8, 9, 13

Answers from Combined Juvenile Courts

Good probation risk -- #2, 5, 9, 14
Not good probation risk -- #4, 6, 7, 8
Comments or qualifications:
- #6 -- "Not without treatment"
- #9 -- "If home or foster home is adequate"
- #14 -- "Depends upon degree"
- #16 -- "All depending on the individual"

Not answering this question -- #1, 3, 10, 11, 12, 13, 15

Answers from Circuit Court Level

Good probation risk -- #11, 12, 37
Not good probation risk -- #1, 2, 8, 13, 16, 17, 19, 21, 24, 27, 28, 29, 31, 43, 44
Comments or qualifications:
- #3 -- "Doubtful, unless given treatment other than law affords"
- #6 -- "Depends on individual. Same as any mentally disturbed person"
- #11 -- "If under a proper probation officer"
- #13 -- "Unless under professional advice"
- #14 -- "Some are, some are not."
- #22 -- "Seldom a <u>good</u> risk"
- #24 -- "Except under observation and treatment"
- #27 -- "Not unless he has recovered fully"

Not answering this question -- #4, 5, 7, 9, 10, 15, 18, 20, 23, 25, 26, 30, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42

APPENDIX E-17

Answers from Magistrate Court Level

Good probation risk -- #1, 6, 17
Not good probation risk -- #2, 4, 15
Comments or qualifications:
  #1 -- "Under supervision"
  #2 -- "Not without special treatment"
Not answering this question -- #3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 16, 18, 19

APPENDIX E-18

DEGREES OF MODIFIABILITY AND EXTENT OF CURES

Question: Do you think of the psychopath as representing modifiable human material?
a. Yes
b. No
c. In part modifiable
To a slight extent
To a considerable extent
Have you ever known psychopaths to be "cured"?
a. Yes
b. No
If so, what do you consider to be the salient factors in the cure?

Answers from Psychiatrists in State Mental Hospitals

Modifiable-Yes -- #7, 32, 36 (rarely), 42, 47, 48, 50, 68, 93
Modifiable-No -- #2, 6, 11, 17, 28, 31, 55, 56, 58, 64, 65, 73, 74, 76, 82, 85, 92
Modifiable to a slight extent -- #1, 3, 5, 8, 9, 12, 13, 14, 15, 16, 19, 20, 22, 25, 26, 31, 33, 35, 38, 39, 43, 44, 51, 52, 57, 59, 60, 62, 63, 66, 71, 72, 75, 77, 78, 80, 81, 83, 84, 86, 87, 94
Modifiable to a considerable extent -- #1 (a few), 4, 10, 18, 21, 23, 27, 30, 35, 37, 46, 49, 53, 54, 61, 67, 70, 79, 91, 95
Comments or qualifications:
#8 -- "If conditions are to their liking"
#9 -- "Very slight"
#31 -- "Possibly"
#35 -- "Depends on individual cases and much further practical knowledge"
#40 -- Checked "In part modifiable," but did not dessignate extent
#48 -- "Adjusted in the same manner that mental deficients can be"
#56 -- "Usually"
#82 -- "Except very mild degree"
#93 -- "If apprehended in early childhood"
Not answering this portion of question -- #24, 29, 41, 69, 88, 89, 90
Psychopaths cured-Yes -- #1, 3, 7, 13, 18, 23, 26, 27, 30, 31, 33, 34, 35, 36, 40, 47, 50, 57, 59, 70, 72, 78, 84, 86, 95

APPENDIX E-18

Answers from Psychiatrists in State Mental Hospitals
(cont'd.)

Psychopaths cured-No -- #2, 4, 5, 6, 8, 9, 10, 11, 12, 14, 15, 17, 19, 20, 21, 22, 24, 25, 28, 32, 38, 39, 42, 43, 44, 45, 46, 48, 49, 51, 52, 53, 54, 55, 56, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 71, 73, 74, 75, 76, 77, 79, 80, 81, 82, 85, 87, 91, 92, 94

Factors in cure:

#3 -- Strong positive transference to some individual intelligently interested in patient's welfare

#7 -- Institutionalization with attention to individual problem and psychotherapy

#18 -- Some psychoanalytical approach. Complete change in environmental vicissitudes

#26 -- Financial security, satisfactory home life. Maturation

#27 -- Analytic psychotherapy -- prolonged hospitalization. Careful study of environment to which he returns

#33 -- Late maturity or change of environment. Usually between 20-30

#34 -- Reaction to a life crisis

#35 -- Some degree of ego integrity, emotional maturity, facilities for real psycho- and social therapy

#36 -- Discovery of the underlying psychic traumata or psychogenic factors and correction. This is a difficult job and can rarely be done

#40 -- Patience, training, education, treatment and maturation

#47 -- Prolonged hospitalization with constructive occupational therapy

#57 -- Satisfaction of the "Ego"

#70 -- Psychotherapy in hands of competent psychiatrist from 1-3 years

#72 -- Achieving maturity later than normal persons. Extremely favorable well-controlled environmental factors

#78 -- Mental hospitalization for several years for mild cases

#86 -- Prolonged re-habit training or reconditioning. As grow older, settle down

#95 -- Psychotherapy and modification of environment in community

Comments or qualifications:

#12 -- "But have seen them improved"

#21 -- "But improved to such an extent that they have become self-supporting and law-abiding"

APPENDIX E-18

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Comments or qualifications (cont'd.)
- #30 -- "To the extent of making a reasonably good community adjustment"
- #43 -- "I think their 'psychopathy' can be utilized and directed because they do so well under institutional supervision."
- #70 --"In the sense of making an adjustment so that they got along well within their society"
- #74 -- "I think it quite questionable if they are ever cured. I have seen some settle down into useful work, however, Whether they will remain apparently stable, time alone will tell. Also, the question remains, Was this individual a real psychopathic, after all?"
- #77 -- "Age sometimes tends to mature them and aid their judgment."
- #84 -- "I have known some to adjust well outside the hospital. Perhaps the diagnosis was wrong."
- #93 -- "Improved maybe through complete psycho-therapy"

Not answering this portion of question -- #16, 29, 37, 41, 69, 82, 86, 89, 90

Answers from Psychiatrists Attached to Correctional Institutions

Modifiable-Yes -- #1, 3, 6, 14, 30
Modifiable-No -- #29
Modifiable to a slight extent -- #4, 7, 10, 12, 13, 15
Modifiable to a considerable extent -- #2, 5, 8, 9, 11, 28
Comments or qualifications:
- #1 -- "With intense, individual therapy under favorable institutional conditions"
- #12 -- "These cases may occasionally adjust in unique environments in which they are able to express their eccentricities without coming in conflict with society, i.e., in unusual occupations."
- #14 -- "Especially the younger psychopath"
- #30 -- "Under certain environment"

Not answering this portion of question -- #16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27
Psychopaths cured-Yes -- #1, 3, 6
Psychopaths cured-No -- #4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 28, 29, 30

APPENDIX E-18

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

Factors in cure:

#1 -- Intense individual therapy under favorable institutional conditions (Everything in most institutions militates against their adequate treatment).

#2 -- Some appeared to mature emotionally and become eligible for release on parole from the institution and made good in society.

#3 -- The attainment of insight, emotional instability [sic] and a socially acceptable goal

#6 -- "probably maturation process"

Comments or qualifications:

#8 -- "But many do well under supervision"

#13 -- "If one gets well, there was a possible mistake in the diagnosis."

Not answering this portion of question -- #16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27

APPENDIX E-19

RECOMMENDED TREATMENT

Question: Do you think that the psychopath who commits a crime requires a method of treatment different from that required by other law-breakers?
a. Yes
b. No
If so, what do you think should be the main points of difference in treatment?

Answers from Psychiatrists in State Mental Hospitals

Answering "No" -- #1 (for majority), 2, 5, 6, 8, 11, 17, 19, 38, 55, 58, 60, 67, 71, 73, 75, 76, 78, 82, 85, 94
Answering "Yes" but not giving points of difference -- #4, 9, 10, 23, 30, 37, 42, 44, 49, 50, 59, 63, 66, 74, 79, 81, 83, 91, 92
Answering "Yes" and giving points of difference:
#1 (for some) -- Intensive psychological study; increase insight; guidance; re-education; capitalize on assets that are present.
#3 -- Psychotherapy instead of punishment.
#7 -- The case should be approached as one of psychiatric rather than social significance.
#13 -- Education and treatment.
#14 -- An evaluation of the personality and schedule formulated in accordance with his capacities and limitations.
#15 -- Cared for in a separate institution where psychiatric care should be emphasized and return to the community should depend upon their mental condition.
#16 -- Must be guided by appealing to emotion rather than to intellect alone.
#18 -- Should be segregated.
#20 -- Require more rigid management and closer supervision and long or indefinite periods of institutionalization.
#21 -- Longer confinement in an institution.
#22 -- Study of factors contributing to patient's condition.
#24 -- Indeterminate sentence in a special institution.
#25 -- Training in deferring gratification of appetities. Training in accepting responsibilities.
#26 -- More stress on education.
#27 -- More direct supervision in hospital. Prolonged hospitalization. Extreme care in allowing him out of hospital.

APPENDIX E-19

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Answering "Yes" and giving points of difference (cont'd.):

#31 -- Depends on individual case
#32 -- Psychiatric study
#33 -- Psychiatric examination and a determination of the basic factors or personality difficulties causing such behaviour disorders.
#35 -- Special neuropsychiatric and psychology studies and resultant psycho- and group therapy.
#36 -- Careful psychiatric diagnosis and treatment of type needed; provision for indefinite custody if indicated by failure of response to therapy, rather than a definite sentence, with release regardless of condition, with inevitable further antisocial behavior.
#39 -- More nearly like in mental hospitals
#40 -- Correctional institution with psychiatrist in consultant capacity to make the necessary examinations to assist and to advise in management, and to give psychotherapy.
#43 -- Closer supervision, which may mean a separate institution
#45 -- Special institution
#46 -- Intense research into etiology of psychopathy
#47 -- Closer supervision
#48 -- Psychotherapeutic -- sublimation utilized. Segregated from influence of others
#51 -- Segregation and closer oversight
#52 -- Observation, segregation, psychotherapy, industrial and occupational therapy. Re-education
#53 -- Segregated from non-psychopaths
#54 -- Separate institution, emphasis on re-education, provision for vocational training
#57 -- Supervision, re-education, rehabilitation.
#61 -- Prolonged institutionalization with active program involving physical assignments and psychotherapeutic recreation.
#62 -- Strict discipline and indefinite supervision
#64 -- More scientific psychiatric and psychological study with improved methods of treatment
#68 -- A combination of appropriate disciplinary atmosphere plus attitudes designed to develop positive transference with goal of causing introjection of good father figures.
#70 -- Treated in a special section of penitentiaries under the direction of a psychiatrist, or in a special ward in connection with state hospitals.

APPENDIX E-19

Answers from Psychiatrists in State Mental Hospitals (cont'd.)

Answering "Yes" and giving points of difference (cont'd.):
- #70 (cont'd.) -- Should never be discharged from the institution, but should always remain on parole even if he makes a satisfactory adjustment.
- #72 -- Indeterminate sentence; segregation from criminals of more normal mentality, preferably by separate institution; single sleeping rooms and intensive supervised activity to minimize perverted sex behavior; training and supervision predominantly under the direction of a psychiatrist; release should be conditional and only when responses to institutional program have been manifestly favorable; indeterminate parole with frequent checkups during parole period.
- #77 -- Segregation in some place with greater custody than a mental hospital
- #80 -- Special institution
- #84 -- Perhaps some may derive some benefit from psychotherapy; others may require permanent institutionalization.
- #86 -- The matter should be individualized, personality dynamics worked out and interpreted with patient. Attitudes changed if possible by psychotherapy and by hospitalization program.
- #87 -- Permanent segregation for those showing criminal trends, supervision by social agencies of other less antisocial groups.
- #93 -- Educational programs requiring concentration and self-control, intensive rapport with the therapist who stresses patient's constructive effort.
- #95 -- Psychotherapeutic approach

Comments or qualifications:
- #31 -- "In certain instances"
- #42 -- "If psychotic"
- #82 -- "With perhaps individual exceptions"

Not answering this question -- #12, 28, 29, 34, 41, 56, 63, 69, 88, 89, 90

Answers from Psychiatrists Attached to Correctional Institutions

Answering "No" -- #1, 7, 10, 27

Answering "Yes" but not giving points of difference -- #25

APPENDIX E-19

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

Answering "Yes" and giving points of difference:

#2 -- More careful psychiatric study and closer custodial supervision. Better study is needed before most psychopaths are released from institutions.

#3 -- Segregation with psychiatric treatment

#4 -- Long term plan. Cannot live up to rules of other inmates; less should be expected.

#5 -- A longer time is necessary. Sometimes continuous segregation as differentiated from short time care for the accidental or inadvertent offender.

#6 -- Needs a lot of individual attention. Varying degrees of segregation. Intensive recreational and work program to keep him occupied all of the time. Individual or group psychotherapy

#9 -- It becomes a medical case for psychiatric and psychological care primarily.

#11 -- He is ill; other law breakers are presumably not.

#12 -- Indeterminate commitments as long as considered dangerous. Special isolation facilities away from other groups. Treatment as psychiatric rather than penal problem

#13 -- They should be segregated (in prisons) and sentenced for an indefinite length of time, with very careful pardoning power exercised.

#14 -- Some attempt should be made to teach him to live on the reality principle instead of adhering to the pleasure principle: of course, this would necessitate a complete psychiatric appraisal with modified psychoanalysis.

#15 -- Segregation in especially designed institution for care and training

#22 -- More thorough study of the personality, developmental and social history from infancy up

#23 -- More discipline and proper guidance. See that they are forced to obey rules and regulations. Re-education

#24 -- Intensive psychiatric treatment

#26 -- While confined should have psychiatrist's help and guidance.

#28 -- Treatment should be from the mental standpoint rather than the penal. If the individual must be removed from society he should be placed in an institution where psychiatric treatment is available.

#29 -- Custody

#30 -- Special institutions

APPENDIX E-19

Answers from Psychiatrists Attached to Correctional Institutions (cont'd.)

Comments or qualifications:

#1 -- "I do not feel that diagnosis per se is any index of basic dynamic problems. Especially is this true for such a variable, befogged category as psychopathy."

#7 -- "Unless they are frank committable cases"

#8 -- "Treatment is individual matter, not based on any diagnostic stereotype."

#22 -- "Absolutely"

#27 -- "If facilities, a specific progr.m and specific treatment of proven value were available it would certainly be justifiable and a very good investment to provide for the psychopathic group. Until we know more about the psychopath and discover some specific treatment, I think it advisable to carry on further studies in this field. Such studies should include different types of therapy for small numbers. In the meantime those who are accessible should have psychiatric treatment and those who experience mental episodes should be provided with hospital care."

Not answering this question -- #16, 17, 18, 19, 20, 21

Answers from Psychologists in Correctional Institutions

Answering "No" -- #5

Answering "Yes" but not giving points of difference -- #1

Answering "Yes" and giving points of difference:

#2 -- Along psychiatric lines, but without too much pampering. Longer period of treatment necessary. Physical and emotional maturity the most leveling factors for the psychopath. Prognosis usually doubtful to poor.

#3 -- More psychotherapy with efforts made to give them some feeling of security and a sense of responsibility for their own actions.

#4 -- Intensive psychotherapy by fully trained workers, medical or non-medical

#6 -- Long term confinement with reeducation, integration into an organized institutional cultural setting with increased responsibilities and independence.

#7 -- They need psychotherapy rather than mere incarceration, rather more intensified attention by the psychological and educational departments. (Alas! how

APPENDIX E-19

Answers from Psychologists in Correctional Institutions (cont'd.)

Answering "Yes" and giving points of difference (cont'd.):
#7 (cont'd.) -- little is actually done in this field).
#8 -- As any other ill person

Answers from Superintendents of Juvenile Correctional Institutions

Answering "No" -- #11, 19, 22
Answering "Yes" but not giving points of difference -- #9, 12, 14, 18
Answering "Yes" and giving points of difference:
#1 -- Should receive special medical care and special security to insure his remaining in the program over a continuing period of treatment.
#2 -- Special treatment unit with research, clinical, and security features
#3 -- Don't know
#5 -- An institution established solely for persons of this nature
#6 -- Special medical and psychiatric care and supervision, and the recommendations of these specialists followed according to the requirements of the individual case.
#7 -- Require more individual care and guidance
#8 -- Treated at some clinic by specialists
#10 -- True cure . . . has not yet been found; until the answer is found, the treatment should be directed more toward a permanent protection of society.
#13 -- On basis of mental condition
#15 -- More sympathetic. Careful study
#16 -- Depend on the advice of the psychiatrist
#17 -- Longer period within the institution; placement within the institution with understanding workers; protection from other inmates who may tease or mistreat him; special preparation for release.
#31 -- Individually
#32 -- More individual treatment than that possible in an institution such as ours
#33 -- Custody plus treatment
#34 -- Should have psychiatric services or studies and if prognosis is poor, provision should be made for permanent custodial care.
#38 -- Institutions primarily set up for this type of person

APPENDIX E-19

Answers from Superintendents of Juvenile Correctional Institutions (cont'd.)

Answering "Yes" and giving points of difference (cont'd.):
- #37 -- Approach from treatment rather than punitive angle
- #38 -- Medical treatment and the services of a psychiatrist. Not many of them can stand any kind of regular routine or regimentation, and a different program should be set up for them.

Comments or qualifications:
- #19 -- " . ... until we know more about the psychopathic personality, and . . . those using the term so frequently can better define it, then I am unwilling to attempt a treatment program for this particular type of individual that is very much different from any other maladjusted person. It seems to me that the term psychopathic is being applied so frequently, that certainly to me, it has little or no meaning, except that it indicates that both the medical and social work professions are resorting to a blanket term which in no way properly diagnoses the average individual who is placed in that category."

Not answering this question -- #4, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 35

Answers from Superintendents of Adult Correctional Institutions

Answering "No" -- #4

Answering "Yes" but not giving points of difference -- #1, 2, 7, 8, 10, 12, 13, 16

Answering "Yes" and giving points of difference:
- #6 -- Psychiatric treatment
- #9 -- Segregation and whatever medical treatment is necessary
- #11 -- Be placed in a smaller group and where more individual attention may be given
- #14 -- Confined in institutions suitable for their proper care and treatment
- #15 -- Avoid placing such inmate where he will be under undue emotional stress. Take into consideration his psychopathic state when discipline is required.
- #23 -- Close medical and educational supervision

Comments or qualifications:
- #4 -- "The only exception should be during the periodic disturbances. They require some discipline and should be expected to conform when mentally quiescent. How-

APPENDIX E-19

Answers from Superintendents of Adult Correctional Institutions (cont'd.)

Comments or qualifications (cont'd.):
#4 (cont'd.) -- ever, our technique is to avoid making an issue whenever possible to do so."
Not answering this question -- #3, 5, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27

Answers from State Departments of Welfare

Answering "No" -- #15, 23
Answering "Yes" but not giving points of difference -- #1, 5, 10, 16, 33
Answering "Yes" and giving points of difference:
#2 -- Need for a psychiatrist experienced with children and for another facility in addition to present juvenile industrial schools, adult prisons, and mental hospitals.
#7 -- An especially controlled institutional setting where discipline is definite and control can be exercised throughout a real training period, followed by competent psychiatric case work service on parole.
#8 -- Intensive treatment by psychiatrist
#12 -- The establishment of a cause-effect, the ward-punishment program to build up the super-ego which he lacks.
#13 -- Protective custody
#18 -- I think that an institution for psychopaths is needed. Under our present sanity laws, it would be almost impossible to adjudge a psychopath as a non compos mentis. The law itself needs to be changed so that these dangerous personalities can be incarcerated and given lifetime custodial care if and until such time as medical science has found some effective means of treatment.
Comments or qualifications:
#15 -- "Each case should be treated according to the diagnosis. The method is the same, but treatment in each case would be different."
Not answering this question -- #3, 4, 6, 9, 11, 14, 17, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32

Answers from Independent Juvenile Courts

Answering "No" -- None
Answering "Yes" but not giving points of difference -- #1, 2, 3, 6, 12, 14

APPENDIX E-19

Answers from Independent Juvenile Courts (cont'd.)

Answering "Yes" and giving points of difference:

#4 -- Society should be protected from the psychopath; psychopaths should be compelled to receive such treatment as is recommended by psychiatrists.

#5 -- Closer supervision

#7 -- Specialized treatment and training

#10 -- 1. If commitment is necessary, then commitment to an institution where the child can have intensive psychiatric treatment.

2. Instead of being under the care of a probation officer, referral to our psychiatric treatment clinic where the child can have psycho-therapy and the mother of the child can be taught to understand the child's needs.

#11 -- Firmness in complying with regulations; sufficient period to establish stability; create new outlook on own problems; return to environment capable of carrying on the institutional progress.

#15 -- Definite follow-up programs with a recognized psychiatrist

Not answering this question -- #8, 9, 13, 16

Answers from Combined Juvenile Courts

Answering "No" -- #14

Answering "Yes" but not giving points of difference -- #4, 6, 7

Answering "Yes" and giving points of difference:

#2 -- Close supervision by a friendly case worker who is capable of winning the child's confidence. Encouragement of the child to think of himself as normal rather than abnormal and to take part in all normal activities. Education of his family so that they can understand the child's problem and will give willing and intelligent cooperation with the worker.

#5 -- Psychiatric treatment

#8 -- Attempt to remove mental barrier

#9 -- Study of boy or girl to ascertain what steps can be taken to help. Punishment, if any, for crime committed is decidedly secondary.

#16 -- Mental treatment rather than discipline

Comments or qualifications:

#14 -- "If treatment is based on welfare of child rather than criminal proceedings"

Not answering this question -- #1, 3, 10, 11, 12, 13, 15

APPENDIX E-19

Answers from Circuit Court Level

Answering "No" -- #1, 17
Answering "Yes" but not giving points of difference -- #2, 6, 8, 10, 12, 16, 18, 19, 23, 29, 31, 37
Answering "Yes" and giving points of difference:
- #11 -- Difference largely in counselling. He should be aided in getting work that he likes and that pays his way in life. All under constant supervision.
- #13 -- Formation of mental concepts and physical habits of conforming to social standards with a crystallization of proper social ideas
- #14 -- Treatment in an institution having psychiatrists and psychologists
- #21 -- He should be treated as sick until it clearly appears he is able to distinguish between right and wrong.
- #22 -- Supervision
- #24 -- Proper diagnosis, treatment, operative if necessary, particularly in sex offenses.
- #27 -- Confined in proper institution for treatment unless he is a psychopathic killer in which case he should be executed.
- #28 -- Treated in hospitals for mental diseases and if they do not respond to treatment, imprisoned for life.
- #43 -- Cure his mental ills
- #44 -- Special institution

Not answering this question -- #3, 4, 5, 7, 9, 15, 20, 25, 26, 30, 32, 33, 34, 35, 38, 38, 39, 40, 41, 42

Answers from Magistrate Court Level

Answering "No" -- None
Answering "Yes" but not giving points of difference -- #2, 4, 8, 10, 15
Answering "Yes" and giving points of difference:
- #1 -- Regard for his personality to make "as is" "as it should be"
- #6 -- Psychiatristical [sic]
- #17 -- Special place of confinement. Examination and treatment by qualified psychiatrist.

Not answering this question -- #3, 5, 7, 9, 11, 12, 13, 14, 16, 18, 19

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